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Chronic Arthritis

BY THOMAS KLEIN, M.D.

DURING the past ten years, the subject of chronic arthritis has interested a great many of the medical profession. Probably in no disease has greater advance been made. It is a fact thoroughly established that chronic arthritis is of infectious origin and everyone realizes the importance of focal infection. Marked strides have been made to alleviate the symptoms of the chronic arthritic patients. The mode of onset, the progression of the disease, the occurrence of fever, leukocytosis, well establish the fact that this disease is of infectious origin. The vast majority of these cases start with swelling of the smaller joints; mostly the metacarpophalangeal and the metatarsophalangeal. The process may be unilateral at the start but usually becomes bilateral as the disease progresses. In the early stages, the joints gradually swell with little or no pain. This gives them the characteristic fusiform appearance. At this time, only the soft tissues around the joint are involved. Upon examination, they have a distinctly doughy feeling. At times, there is a questionable effusion in the joints. Pathologically, this enlargement is due to swelling and hypertrophy of the synovial membrane and capsular ligament. Pain is only present upon pressure and with active or passive motion. The disease progresses with definite periods of acute exacerbation, characterized by fever and its accompanying symptoms, increased pain, stiffness of the joints and the surrounding structure. Frequently there is increased swelling and redness in the joint structures themselves. These periods are always associated with a slight increase in the leukocyte count as compared to the stage during the quiescence. During the acute exacerbations, fever is practically always present, even though it be of small magnitude. During this time, the disease progresses upwards involving the larger joints; namely, the wrist, the elbow, shoulder, ankle, knee, hip, and joints of the spine.

Soon after the beginning of the process, which in itself is essentially a hypertrophy of the periarticular structures, we have an atrophic process set up. This involves the muscles, subcutaneous fat and skin. These changes are undoubtedly due, in many instances, to a reflex atrophy. Volpain's idea, namely,

> an impulse carried from irritated articular nerves alters the trophic activity of the cells in the anterior horns without causing a lesion, but sufficient to cause atrophy and weakness,

is an extremely good one and is the

best explanation offered for this process. It is because of the atrophic condition of the skin, atrophy of the subcutaneous fat and muscles, plus their subsequent contraction which gives the characteristic deformity of this disease. The extensor group of muscles always suffers greater damage than the flexor group and flexor contracture always predominates. This is explained by the fact that nerves which supply the extensors, also supply the joints themselves, consequently they bear the brunt of the irritation to a greater degree. Associated with this degenerative process is a fibrositis involving both the aponeurosis and the muscles themselves. In fleshy individuals, the subcutaneous fat is also caught in the process in the form of a panniculitis. These two conditions account for a good deal of the patient's suffering and will form a very important part in the treatment.

The term, chronic arthritis as here used, designates a large group of cases which have been formerly classified as chronic non-suppurative arthritis, rheumatoid arthritis, chronic infectious arthritis, chronic osteo-arthritis or arthritis deformans. This wide classification is made for the purpose of simplicity. If one studies the pathology of these joints, he will find that atrophy and hypertrophy take place simultaneously, consequently it is ofttimes impossible to make a decision which predominates and therefore a suitable classification. Gout or gouty arthropathy being a purely metabolic disease is not here considered. The same holds true of arthropathies of nervous origin or those occurring in tabes dorsalis (charcot joint), and syringomyelia. The chronic hypertrophic osteo-arthropathies occurring in the course of pulmonary tuberculosis, bronchiectasis, chronic bronchitis, malignant tumors of the lung and various chronic cardiac conditions, are again distinct and are not included in the above term, chronic arthritis. Syphilitic arthritis is again a more or less distinct entity and is not here considered. This, however, does not include that group of cases which have a definite chronic arthritis with an associated underlying syphilitic infection. Villous arthritis is probably a stage of chronic osteo-arthritis and will be considered as such. Chronic spondylitis or spondylitis rhisomelica is a definite form of chronic infectious arthritis and will be included in this series of cases.

The analysis of the material submitted comprises the study of one hundred and eighty-six cases. Realising the complexity of a chronic arthritic, we have endeavored to look at these cases from all angles and wherever possible to find sources of infection. This, however, in many, was an absolute impossibility.

CHART NO. 1—AGE INCIDENCE

Years of Age	*Cases*	*Per Cent*
Under 20	2	1
20–30	22	12
30–40	36	20
40–60	97	51
60–over	30	16

As you will note from the above chart, practically no age is exempt from this type of disease. It is, however, a disease comparatively rare under the age of twenty. When it does occur, it is of an extremely virulent form. The majority of cases occur past middle life. This includes a great group of cases which have been termed metabolic arthritis. They occur after or at about the time of the menopause. This fact, however, does not have an etiological factor. Many of these women have had symptoms for several years, prior

to the occurrence of the menopause. During the menopausal stage, the patient's resistance is lowered and the disease has an opportunity to progress more rapidly.

CHART NO. 2—PROBABLE SOURCE OF INFECTION

	Cases	Per Cent
Intestinal tract	70	37
Tonsils	66	35
Teeth	39	20
Gall Bladder	25	13
Sinuses	6	3
Prostate	2	1
Unexplained	approximately	5

In the studying of this classification of Probable Sources of Infection, we wish to call attention to the fact, that the vast majority of these patients have been going the round of various types of specialists before consulting us. Consequently, the sources of infection have been removed. Owing to this fact, infections of the mouth and upper respiratory tract occupy a less important part in this analysis. In searching for focal infection, let us bear in mind that the vast majority of these cases are of multiple foci rather than one single focus. It is for this reason that we ofttimes fail in getting the desired result after the removal of diseased teeth, tonsils, etc. Another point of extreme importance to remember is that after the primary focus has been removed, the lymphatics which drained this area of infection, still harbor the organism and may still be an infecting factor. Teeth and tonsils correctly occupy the foreground as the most frequent sites of focal infection in the vast majority of cases. Following these are the sinuses, gall bladder, prostate, infected ingrown toenail, ulceration along the intestinal tract, mediastinal lymphnodes, etc. The female pelvis in our series of cases has not been found an important factor. In all cases, especially those involving the lower portions of the spine and sacro-iliac joints, the prostate and the seminal vesicles are to be examined with great care. Ofttimes the first massage of the prostate will fail to show any evidence of infection, but upon a subsequent examination, a definite prostatitis will be found to be associated. When found, as a source of infection, we are too prone to look upon it as a gonorrheal type of disease. The streptococcus may long persist without any gonococci being found. Non-surgical biliary drainage done in an aseptic way may afford many opportunities for the study of the gall tract for infection. With the wide use of the Graham Test, one will have a very valuable asset in the study of gall bladder disease. In this group of cases, the intestinal tract has acted as a probable source of infection in 70 per cent. A great many of these were in the form of visceroptosis and intestinal stasis. Forty-five per cent of our cases were of normal weight according to age, height and sex. Of these cases, four show evidence of visceroptosis and stasis. Only 15 per cent of our cases were overweight. Two of these show an acquired visceroptosis. Forty-three per cent of our cases were underweight; of these, 60 per cent showed definite evidence of ptosis and stasis. It is for this reason that the gastro-intestinal tract forms a tremendous factor in the care of the arthritic patient. In our experience, the diet is of importance only inasmuch as it has to do with the gastro-intestinal tract. The gall bladder is again extremely important. In this series, 25, or 15 per cent, showed definite evidence of disease.

As before mentioned, a great many of these cases having been studied elsewhere before coming under our observation, tonsils and teeth occupy

a less important phase than the gastro-intestinal tract. The sinuses occupy an extremely small part. We might state that in the sinus work, all cases, irrespective of having symptoms or not, were trans-illuminated and if any cloudiness was found, the sinuses were X-rayed. This was done to obviate any possibility of overlooking any hidden infection. The prostate was found to be a source of infection in only two cases. This is probably due to the fact that a great portion of these patients were females. In the tonsil work, we wish to call attention to the fact that lymphoid tissue, which ofttimes regrows in the tonsillar fossae or bits of tonsillar tissue which remain, may harbor rich growths of streptococci and act as a focus of infection. When, on examining these cases one finds injected tonsillar pillars and possible small cervical adenitis, one should never be satisfied until after making tonsil cultures from these apparently benign lymphoid growths. Tonsillar cultures may not be of any great clinical use because of mouth infection, especially during the winter months when the so-called "colds" and sore throats are so prevalent. However, when rich growths of streptococci are obtained, it is an additional link in the chain of evidence in condemning that portion of the patient's anatomy. The prevalence of streptococcus viridans and streptococcus hemolyticus is about equally proportioned in these cultures.

CHART NO. 3—BLOOD PRESSURE

	Cases	Per Cent
Normal	93	54
Hypertension	16	9
Hypotension	64	37

Ninety-three cases, or 54 per cent, showed a normal blood pressure. The hypertension cases occupied a very small portion, or 9 per cent. In this group occurred cases of benign hypertension, generalised arteriosclerosis and chronic nephritis. The hypotension cases occupied a rather large percentage, 37 per cent. It is interesting to note that 75 per cent of these hypotension cases were of the viscer-optotic variety, the hypotension, in all probability, being only a part of their general condition.[1]

CHART NO. 4—BLOOD COUNT

	Cases	Per Cent
Normal	128	70
Secondary anemia	48	30
Leukocytosis	18	10
Leukopenia	43	24
Normal Count:		
Red blood cells	4,000,000	
White blood cells	6,500 to 9,000	
Haemoglobin	80 per cent	

It is surprising to note the large number of patients who have an absolutely normal blood count in this type of disease. In this group 128 cases, or 70 per cent, showed a normal count. In 40 cases, we had a secondary anemia of moderate degree. In 18 of our cases we had a definite leukocytosis. The vast majority of these cases were examined during a period of acute exacerbation; 43 cases, or 24 per cent, showed a definite leukopenia. The differential count in these leukopenics showed a relative increase in the number of lymphocytes. It has been our experience that during the period of quiescence, a lymphocytosis exists, while during the period of acute exacerbation, the leukocytosis gives way to polymorphonuclear variety.

Blood chemistry in this type of case is of extremely little value. You will note from the following chart that the vast majority of the cases have an absolutely normal chemistry. With

[1] These blood pressure readings were based upon a normal pressure—120 systolic in an individual 21 years of age. One-half point was added for each additional year of the patient's age.

CHART NO. 5—BLOOD CHEMISTRY

	NORMAL		ABOVE		BELOW	
	Cases	*Per Cent*	*Cases*	*Per Cent*	*Cases*	*Per Cent*
Blood sugar	142	86	12	7.5	10	6
Blood urea nitrogen	138	78	32	18	5	4
Blood uric acid	138	84	24	14	3	2
Blood creatinin	124	98	3	2		
Blood calcium	20	100				

Calculated Normals—Blood sugar	80–120 mg. per 100 c.c. of blood
Blood urea	14– 17 " " " " " "
Blood uric acid	2– 3.5 " " " " " "
Blood creatinin	1 " " " " " "
Blood calcium	9–11.5 " " " " " "

the hypoglycemia, which others have reported to find in this type of case, we did not concur. This may be explained by the fact that we allowed a wide variation—between 80 and 120 milligrams per 100 c.c. of blood as a normal. In 12, or 7.5 per cent, we found a definite hyperglycemia. Several of these were potential diabetics. Like the blood sugars, the urea nitrogen was of very little importance. Thirty-two, or 18 per cent, of our cases, had a slight retention. This, of course, occurred in patients showing other evidence of chronic nephritis. Uric acid estimations were useful in helping us to differentiate between cases of chronic arthritis of infectious origin and those of metabolic origin. In 24, or 14 per cent, we found the uric acid above normal. In several of these, we had a combination of the two conditions existing. This condition might be overlooked if it were not for the persistent high uric acid in the blood. Because of the very few cases of chronic nephritis being associated, creatinins were normal in all except 3, or 2 per cent. Thinking that there might be an increase in the amount of blood calcium in these patients because of the marked exostoses occurring, we have endeavored, of late, to determine the blood calcium. Here, as in all of the blood chemistry, we found a normal calcium in 20 of our patients. This comprises all the calciums that have been done in this group. As far as we can tell from such a small series, there is no alteration in the calcium content of the blood in chronic arthritis.

CHART NO. 6—GASTRIC CONTENT

	Cases	*Per Cent*
Normal	32	40
(Free HCL 20–40)		
(Total acidity 40–60)		
Hyperacidity	26	30
Hypoacidity	12	14
Achlorhydria	14	16

Fractional gastric work was not done in cases which did not present symptoms. The Ewald test meal was used in all cases and extraction was made by the fractional method. The titration was done immediately after the extraction. Six to eight specimens were collected over a two-hour period in every case. As you will note from the above chart, 32 cases, or 40 per cent, showed a normal curve; 25 cases, or 30 per cent, showed a marked hyperacidity; 12 cases, or 14 per cent, showed a diminution in the acid content. In 14 cases we had an absence of hydrochloric acid throughout the entire two-hour period. These may not be true cases of achylia gastrica because ferments were not tested and, for that reason, the term achylia gastrica has not been used.

Additional metabolic studies, as well as sugar tolerance tests, have been done routinely upon many of this group of cases. The results obtained were very varied and did not lend any additional information as to treatment. Several of the overweight cases showed increased metabolic rate. Many of the undernourished, underweight cases showed a decreased metabolic rate. In some of the overweight cases a positive sugar tolerance test was obtained. This, then, was of value in the correction of the patient's diet. Routine Wassermanns should be done because an underlying syphilitic infection will ofttimes prevent getting the desired result in other forms of treatment. It has been our experience that a patient who has a chronic arthritis with an underlying syphilis will not improve from an arthritic standpoint until the syphilis has been entirely eradicated. Stool examinations are, again, of only moderate value. Their primary importance is in relationship to the gastro-intestinal tract and not to the arthritis.

Mode of Treatment

THE mode of treatment may be divided into (1) general care of patient and (2) drug or vaccine therapy. Treatment is not started upon any of these cases until after a very thorough and exhaustive study has been made and all foci of infection have been removed. These patients are usually placed in hospitals for a short time. Rest in bed is a very essential element in these cases and a few weeks in bed usually afford benefit. This is of primary importance in the undernourished case, especially the viscer-optotic. The foot of the bed is elevated nine inches and the patient is encouraged to lie upon his right side to hasten gastric emptying after each meal. The diet in all these cases is one suitable for the gastro-intestinal findings. In the undernourished variety, six meals a day are usually given if the patient can at all tolerate them. These diets are usually high in fat and we are fond of giving the patients cream and Celestine Vichy, in equal parts, between meals. In so doing, we can usually get the patient to take eight to twelve ounces of cream per day without any gastric or colonic discomfort. If there is any evidence of intestinal stasis, colonic irrigations are given, washing out the colon with eight to twelve quarts of water. This is usually repeated twice a week. If the patient is at all ambulatory, a Rose belt is applied to hold up the colon during the time the patient is out of bed. Patients do not complain of the adhesive plaster but are usually gratified with the sense of support that they receive. Patients usually gain weight more rapidly when such support is worn. When the skin becomes sensitive, various types of abdominal belts and corsets are then used. The choice of belts and corsets depends a great deal upon the type of abdomen with which you are dealing.

Along with the general care of the gastro-intestinal tract in such a manner, we routinely give iron and arsenic or sodium cacodylate hypodermically. Even though the patient has a normal blood count, the iron and arsenic seem to give them additional tone. Electrotherapy in the form of electric bakes and hydrotherapy in the form of hot and cold compresses, etc., are used routinely in all cases. It must be remembered, however, that in a few this type of treatment will aggravate the condition and if found to do so, should be discontinued immediately. It has been our experience that massage should be started rather late in the disease. The muscles are too

inflamed to be massaged at the start. We encourage our patients to get as much motion in the affected extremity as possible, thinking that the active motion obtained is, by far, more beneficial than the passive. At the same time, the patient will not, because of the pain, damage the joints. The over-enthusiastic masseuse is very apt to cause damage to the inflamed joint. The contractures are, to a great extent, overcome by the patients themselves. This is done by hyperextension without weights. Mechanical appliances are not used until after the patient has endeavored by exercise and hyperextension to strengthen his own joints. Buck's extension and braces with thumb screws are placed upon patients who otherwise are unable to break up the associated fibrositis.

In addition to the above general care of these patients, we have for the past ten years, used foreign proteins in the form of Coley's Fluid. Coley's Fluid was selected because of its high-powered potency, plus the fact that it is always easily obtained upon the market. We feel that in the use of foreign proteins, in these cases, the most benefit is derived by repeated small protein stimulations and not by generalised reactions. Consequently, in all cases, we have been inclined to keep the dose extremely small; in many cases, not exceeding three or four minims at the end of a year's treatment. We have also noted that as the vaccine is continued over a long period of time, the people seem to become hypersensitive to it and it is necessary to reduce the dose. In starting the vaccine, it is therefore very essential to start with a small dose—usually a quarter minim in one c.c. salt solution or sterile water. This is given subcutaneously. Three types of reaction are experienced—focal, local and general. It has been our practice to tell these people that after the vaccine injection they will have pain in joints heretofore unknown to be involved. The pain in the joints is invariably increased after the first four or five injections. This, thereafter, will gradually be diminished and the period of freedom from pain will gradually be increased. At the site of injection a marked erythematous area develops. This fluid is quite irritating and, at times, you will think of abscess formation. This we have not experienced, but for a week or more the hard indurated nodules persist. These patients are hypersensitive to the vaccines and the dose must be increased very slowly. This hypersensitivity persists surprisingly throughout the course of treatment and varies with each individual. The largest dose of vaccine given was 10 minims and that after eight months' treatment. In a case of fifteen years' duration in which we obtained a beautiful result, we could never give over four minims without causing a general reaction. It is to be remembered that in these cases of long standing, the patients are usually anemic and markedly undernourished. The pain has been severe and their nerve is broken. Consequently it is important to try to avoid a general reaction. While this does not do the patient any harm, it is bad from a psychological standpoint. In addition, they have been through so many hands and tried so many forms of treatment that they are always dubious of any new treatment and especially so if they are to have more pain in the beginning.

The time interval of the injections varies from three to four days at the beginning, gradually being lengthened to five or six days as the symptoms improve. It has been our rule to gage

the time of injection and the size of the dose entirely upon the local reaction. If it be severe, the same dose is repeated. At times it is necessary to repeat the same dose as many as four or five times before increasing the vaccine. Especially is this true as the larger doses are used. The vaccine is continued until the patient is clinically well. Unfortunately, the time of stopping the vaccine is entirely empirical, as we know of no way of telling when the infection has been entirely killed out.

In September, 1926, Young and Youmans, of the University of Michigan, published in the *Journal of the American Medical Association*, their results in the treatment of chronic arthritis with ortho-iodoxy-benzoic acid. Their results were surprisingly good and since then the drug has become widely used in the treatment of this disease. The ammonium salt (ammonii ortho-iodoxy benzoate), because of its ready solubility and its low toxicity, is the drug of widest use. It is primarily a streptococcocide, and secondarily an analgesic. Personally, we do not believe that its action is that of a foreign protein, such as Coley's Fluid. It is given in one-gram doses and administered intravenously. The drug is dissolved in 100 c.c. normal salt solution or freshly distilled water, and given intravenously by the gravity method, twice weekly. The reaction obtained is severe burning sensation of all mucous membranes, including, according to time of appearance, tongue, buccal mucous membrane, nose, eyes, and gastro-intestinal tract. This burning sensation is usually felt in all the affected joints as well as around the matrix of the finger nails. Nausea, vomiting, and purgation are at times met with, especially with the first injection when the nervous manifestations are usually great. Marked febrile reactions have only been met with in four or five of our sixty cases. In one case, a marked urticarial eruption of short duration followed the injection, but in no way was disturbing to the patient. We had the opportunity in seeing one case of a generalised dermatitis, not unlike that which follows arsphenamine, after the injection of the drug. We have found less reaction when the drug is administered in saline solution than when sterile water was used as the solvent. The rate of injection also seems to play a definite rôle in the amount of reaction. The slower the administration (15–30 minutes), the less reaction obtained. Young and Youmans advised giving the drug in a series of six to eight injections, with a period of rest between the series. Since the drug is not accumulative, and with the patient under careful observation, we see no need for the interruption. Personally, we feel there is no limit to the number of doses to be administered. The greatest number given to any one patient has been thirty-two doses; a few doses do not cure. It must be administered in the same manner as arsphenamine, giving sufficient to obtain the desired effect; namely, the alleviation of the patient's symptoms, especially the pain.

Recently the calcium salt of the ortho-iodoxy-benzoic acid has been administered by mouth, with some benefit. The calcium salt is used in preference to the ammonium salt because of its slower solubility and its lessened gastric irritability. This drug is not, however, free from gastric irritability, and frequently causes epigastric burning and nausea. In one of our cases, with a history of gastric ulcer fifteen years previous, after the fifth dose the patient vomited blood. This drug is far inferior to the ammonium salt when administered

intravenously and should only be used as an adjunct to the ammonium salt, or in those cases where it is impossible to follow the intravenous method.

The benefits derived from both drug and vaccine therapy are diminution of pain, plus a loosening of the joints. The acute exacerbations which are so characteristic of the disease are gradually diminished and are finally obliterated. It is remarkable to see the rapidity of diminution in the size of the joints. The patient, through his own efforts, will begin to move the joint and loosen it, as soon as the pain subsides. In the febrile cases, the temperature gradually returns to the normal course. The patient's general health improves and he soon loses his toxic appearance. The gain in weight is quite remarkable. One patient who has been under the treatment for the past seven months, has gained 42 pounds.

In conclusion, it must be said that the treatment of these cases is as complex as their source of infection. The more thoroughly they are studied, the more frequently we believe we shall find definite evidence of streptococcus infection. Coley's mixed toxins, when used cautiously and over a prolonged period of time, and of late the intravenous administration of ammonium ortho-iodoxy benzoate, have in our hands, given us satisfactory and pleasing results.

Nursing Care of Arthritis

By Elizabeth Dorrell, R.N.

IT is the generally accepted belief that certain forms of arthritis are secondary to a focus of infection somewhere in the body, while other forms are due to disturbances of metabolism, in which the infectious element may play a large part. A prompt and thorough search of the body for the possible source of infection is therefore necessary.

As the treatment covers the location and the removal of the cause, if possible, and improvement of bodily nutrition, the nurse's life is a busy and a most interesting one—the patient requiring constant and skillful nursing.

Arthritic patients, as a rule, are easily depressed and discouraged, and it is of the utmost importance that the nurse maintain a cheerful frame of mind under the most disheartening circumstances. A pessimistic attitude is never justifiable and is almost certain to react unfavorably on the patient.

Many tests and experiments may be necessary, and the nurse must have a thorough knowledge of all nursing procedures and a keen understanding of the technic of the ordinary laboratory experiments, in order to cooperate intelligently with the physician and carry out his directions faithfully. Instructions may be given for a gastro-intestinal X-ray, cholecystogram, kidney X-ray, cystoscopy, proctoscopy, Mosenthal test, collection of feces and urine for culture, gastric analysis, biliary drain, aspiration of joints, intravenous and intramuscular injections, phenol-sulphonephthalein test, blood sugar, sugar tolerance test, basal metabolism, bladder irrigation, etc., and the nurse will be held directly responsible for the

preparation if not the actual performance of many of these tests.

During the acute stage, rest in bed is imperative in a well ventilated, sunny room. As active circulation is desired, a daily bath is a necessity. The patient suffers intensely at times, especially during the night, and no effort should be spared on the part of the nurse to induce sleep. A tepid sponge or alcohol rub will ofttimes prove most restful. There may be profuse perspiration of the hands and feet, and these parts should be thoroughly dried and powdered. Special care must also be paid to all bony prominences. As the teeth or tonsils are often the source of infection, the mouth should be frequently cleansed, the teeth being brushed on awakening, after each meal, and at bedtime.

As elimination plays an important part in the treatment, water should be given freely and the bowels should be kept open. Often a colonic irrigation is ordered. This may be given as the routine irrigation, although splendid results have been obtained by preceding the irrigation with a cleansing enema and a colon massage. The irrigation is then started with the patient on the right side, later turned on the back, the greater portion of the irrigation being given in this position. It is completed with the patient on the left side. A kneading massage of the abdomen is kept up during the entire procedure.

As the arthritis may be due to a disturbance of metabolism, the diet should be carefully watched. The majority of patients being more or less anemic, the food should be appetizing and nourishing, the tray served daintily, and a daily record kept of the caloric value of all food taken.

Ambulatory patients should be weighed every second day. Unless contraindicated, bed patients may be placed on a litter and weighed at least weekly.

As patients suffering from arthritis are extremely sensitive to pain, great care must be exercised in handling them. Painful joints may be wrapped in cotton wool and small pads and pillows placed under parts in contact with the bed. Limbs may be splinted or immobilised with sand bags—usually for a short time, only—and pressure of bed linen removed by means of bed cradles. Much comfort is derived from placing a pillow and fracture board in a horisontal position at the foot of the bed, against which the patient may brace his feet if desired.

Pain is a well-known factor in the production of deformity, patients naturally keeping the joints in the position of greatest ease, therefore every precaution must be taken to prevent ankylosis. After the acute stage has subsided, a Buck's extension is sometimes applied for short periods, care being exercised that the limb is kept perfectly straight. A pillow should not be placed under the knee joints at any time unless specially ordered. Small pads under the ankles, however, will add greatly to the patient's comfort and prevent pressure sores. Later the articulations should be manipulated daily and the patient encouraged to use both muscles and joints. To prevent permanent disability, convalescing patients must be gently urged and compelled, if necessary, to walk and perform simple exercises under the direction of the physician in charge.

Baking, local or general, frequently proves very beneficial. This may be accomplished by the superheated dry air method, or the patient may be wrapped in a hot wet blanket and the

heat then applied. A careful watch must be kept during a general bake and the pulse rate taken frequently. Unless contraindicated, tap water or hot drinks may be freely given. If any symptoms of cerebral anemia are noted, the patient should be immediately removed from the bake. If the wet blanket is used, special care must be employed in removing the patient quickly, wrapping in a warm blanket, and protecting well from all draughts. Hydrotherapy is also useful locally in the form of compresses which may be either hot or cold. Diathermy and ultra-violet ray in the hands of an experienced nurse have in some cases proven very beneficial.

As there is usually considerable muscular atrophy in arthritic cases, after the acute stage has passed, massage either local or general is of great value in restoring the atrophied muscles and lessening joint rigidity.

Whenever favorable, the patients should be kept outdoors for a part of each day, but they should be warmly clad and protected against sudden chilling. During this period, they should perform deep breathing exercises. When weather conditions do not permit, the exercises may be taken indoors in the early morning or late evening with bedroom windows open.

The prognosis? Encouraging if the source of infection can be discovered early and yields readily to treatment. Much, however, depends upon the extent of the arthritis, the proper management of the treatment, and last, but not least, the untiring efforts of the nurse.

A Personal "Ask-Me-Another" for 1928

SUGGESTED BY JANE VAN DE VREDE, R.N.

Am I of the opinion that nurses, like ministers, should be "called" to this profession?

What qualities do I possess which make me feel that I inherently belong to the nursing profession?

Do I love nursing above everything as a vocation?

Has nursing made me realise increasingly the responsibilities involved, not only the responsibility of helping perhaps to save life and restore health to patients, but the responsibility I owe to my profession to be a person of integrity, worthy of honor and a credit to it?

In short, am I, as an individual, a credit to this profession? If not, how then can I expect my profession to be fully respected by others?

Do I realise that every time I stoop to do something which is beneath the dignity of my profession I lower the standards of the profession as well as of myself?

Does my profession lend dignity to me, make me anxious to take a part in the work of the world, or does it take away from my prestige?

Do I influence others to come into the nursing profession, or to leave it?

Has my training given me a clearer understanding of life and how to live it in such manner that I am a better woman, or a better potential wife and mother, a better human being? Or is the reverse of this true?

Do I realise that people expect much of me because I am a nurse? That nursing is recognised as an art and is, subconsciously, enshrined in their hearts?

Do I by my own actions disillusion my patients and the public? Do I realise that in this process of disillusionment I tear down the profession and cheat myself, economically as well as spiritually?

Do I personally believe that only nurses with education, refinement, good background, character and training should be members of this profession?

If so, what am I doing to increase my own educational equipment?

The Thermos Bottle a Time-Saver

By Florance R. Unwin, R.N.

IT usually requires the constant attention of a nurse to keep the water bath used in the old method of peptonising milk at a certain temperature while the following method takes very little preparation and no constant watching.

Equipment.—1 pint fresh milk, 1 saucepan, 1 cooking thermometer, 1 Fairchilds Peptonizing powder or tube grs. 22, 1 pint thermos bottle, 1 teaspoon, 1 glass.

Method.—Dissolve one powder or tube in one ounce of cold milk in a glass. Heat milk to 110 or 112 degrees F. in saucepan. Mix the dissolved powder with warm milk, pour into the thermos bottle and cork tightly. Partially peptonised at thirty minutes. Fully peptonized at one hour. Either remove the cork at the end of time and cool, covering with a piece of gauze, or put in a glass jar or bottle. Put on ice.

Peptonizing milk in this manner is a time-saver, especially when quantities are used daily as, for example, in gastric gavages, gastrostogavage, deuodenal feedings, nutritive enemata, in the convalescent diet, for children and for formulas.

Nurses' Records

THE importance of the nurse's bedside or clinical notes has not yet been fully realised by the hospital, or the medical and nursing professions. The nurse has a broader function than to carry out orders and attend to the physical needs of the patient. She must keep an ever watchful eye on the patient to make accurate minute-to-minute observations on the development, progress and course of the disease during the twenty-four hours. The nurse is, so to speak, the third eye of the doctor, the ever watchful eye which is on the patient continuously, whereas the doctor sees the patient in more of an intermittent manner, through a brief visit once or twice a day as a rule. On his visit he can only formulate a proper bird's-eye view of the progress of his patient during the past twenty-four hours by a study of the repeated observations made and recorded by the nurse in his absence. Through such findings he is not infrequently influenced as to the course of treatment or procedure to be laid down so far as the patient is concerned. How very important it is, therefore, to have these observations made accurately and expressed comprehensively. This alone is one strong argument for a higher standard of education for nurses. Indeed I would like to see every young woman who contemplates entering the nursing profession take a preliminary course in psychology and training of observation and judgment.

Occasionally we see the expression on the patient's chart: "Pain in the abdomen." This is worthless as a statement because of its indefiniteness and incompleteness. Such a condition should be more thoroughly described thus: "A sharp intermittent pain in the right lower quadrant, in the region of the appendix, radiating towards the stomach." Information of that kind is valuable to the doctor. Again, we hear or see the expression: "Patient had a pain in the chest." This is useless to the clinician, as it is too indefinite but "Patient had a pain in the right side of the chest in line with the axilla, coming on after coughing," is practical, valuable knowledge to the clinician. A third familiar example, "Patient vomited," is also too indefinite, but when we say "Patient vomited two and one-half ounces of blood-tinged fluid shortly after eating," we will help the clinician in making his diagnosis. In other words, let us see that the symptoms or observations made are described as to how, when, where, etc. We cannot separate the nurse from the case history, the diagnosis, the treatment or the result obtained in any case that requires nursing care. We must recognize her as a reliable factor or agent in these processes.

Therefore, let those in authority teach their student nurses to observe accurately and express themselves comprehensively, so that the record of bedside or clinical observations made by the nurse be a more valuable part of the case history.—From "The Rôle of the School for Nursing in the Hospital," by Malcolm T. MacEachern, M.D.

American School of Nursing in Constantinople

By Clara D. Noyes, R.N.

INTO the East, rich with its mediaeval and classic associations, the American Red Cross penetrated during the years of reconstruction following the Great War and, in the course of its vast program of relief, assisted in establishing a modern hospital and school of nursing at Constantinople, capital of the Turkish Empire. This institution which accomplished so much good, especially in the trying years of the Russian revolution, has shed a rich influence over the Near East, influencing even the governments of these lands to become interested in modern nursing and medicine.

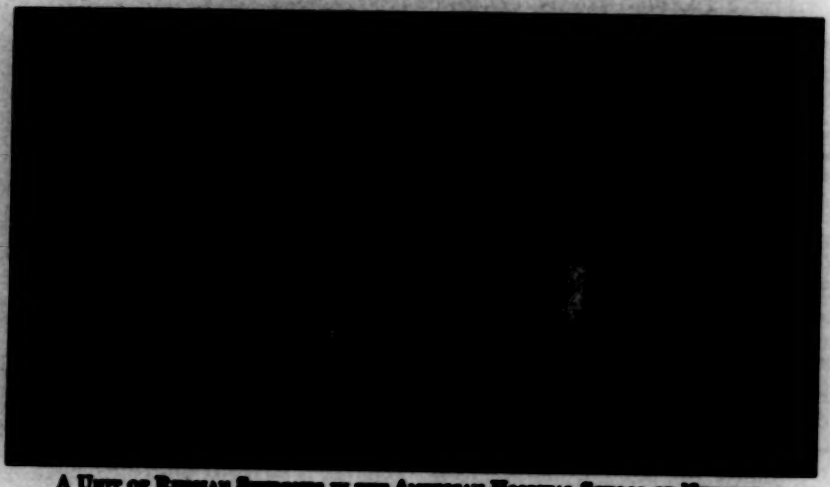
Opposite Constantinople, Queen City of the East in the days of the Roman Empire, is Scutari, located on the Asiatic Coast across the Bosporus, where Florence Nightingale and her "Angel Band" brought comfort to dying and wounded British soldiers during the Crimean War. Here at this place, sacred to the profession of nursing, originated the idea of the Red Cross. Not only did Miss Nightingale's untiring service result in the saving of many lives, but it established nursing as a profession, created a new attitude toward the wounded of war and brought about world-shaking reforms in army sanitary and medical service, and later the flowering of the international Red Cross.

Turkey, like other countries of Europe, received the ministering care of the American Red Cross in the months following the Armistice. Her people were suffering from diseases due to bad diet, from a lack of medical supplies and, on top of her troubles, came to Constantinople, Gateway to the East, the hordes of Russian refugees who had been driven out of the Crimea by the advance of the Bolshevik armies.

Sensing an acute need for trained nurses in countries where extensive reconstruction programs were being carried on, the American Red Cross fostered hospitals and nursing schools in many countries, supplying the leadership so greatly needed and furnishing the necessary supplies. Many of these hospitals and schools were later taken over and continued by their own people, and they stand today as living monuments to the American Red Cross. Among such institutions as these are the hospital and school at Constantinople, modern, well equipped and staffed with trained doctors and nurses in a city of mosques and minarets that had slumbered so long in dreams of its past splendor.

Mrs. Anna Rothrock, who had been assigned as chief nurse for the unit of fifty-four nurses organized by the American Red Cross for service with the Near East Relief, was detached from that service in the spring, 1919, to develop the hospital and school under the auspices of a local committee which included representatives not only of the Red Cross, but of the American College for Women, Robert College, and American interests such as the Standard Oil Company and Near East Relief Society.

The hospital was established first at Stamboul, in a large three-story house, formerly the home of a wealthy pasha, a building in poor repair, badly lighted, and with a total absence of heating and plumbing facilities.



A Unit of Russian Students in the American Hospital School of Nursing, Constantinople

Nevertheless, stoves were installed and the building put into shape. The hospital consisted of wards with from six to twelve beds, and five private rooms of one or two beds, a total of eighty beds, with two large halls for convalescents, an operating room, supply room and dispensary. A year later, Lyda W. Anderson succeeded Mrs. Rothrock. With the help of the American Red Cross, an American teaching staff of five nurses and one dietitian had been secured. An affiliation with the American College for Women, Constantinople, provided for additional instruction by members of the college faculty, making possible a study course that met the requirements of the standard curriculum of the National League of Nursing Education of this country.

In order to develop a native personnel quickly, the length of the course was made two years to correspond with the decision adopted by the American Red Cross Schools of Nursing in the other countries of Europe established after the war. In the requirements for this school, a statement provided that students who were immature or who needed additional instruction or experience would remain six to twelve months longer. The urgent need of preparing nurses for public health work was recognized from the beginning, and in 1922, an elective supplementary course was started. This was included, two years later, in the school course which at that time was increased in length to twenty-eight months.

In June, 1924, according to a new government regulation, the school was placed under the Department of Education. This entailed a conformance to detailed restricting regulations; that is, scheduled instruction in Turkish language, history, and geography and, as classes in English were from the beginning a necessary part of the curriculum, there was considerable difficulty in arranging for the hours of practical work. Teaching from the first Manual of Nursing, written in Turkish, was begun in 1925. This textbook was prepared by the American

nurse staff and met a very important need; up to that time there had been almost nothing printed in Turkish for nurses.

The hospital and school were moved, in 1924, to the old German Hospital, in Pera, the residential section of the city which overlooks the Bosporus and Scutari. This building is well constructed with accommodations for about 100 patients, and is complete, with a special building for general diseases, a hospital of thirty beds for contagious diseases, a large dispensary, a nurses' residence, laundry and greenhouse.

In 1924 Miss Anderson was released and Mary K. Nelson was appointed to replace her. At that time the number of other Americans on the teaching staff was reduced from six to three, three graduates of the school being appointed to the vacancies. The staff was again reduced the following year, when one member was released and two additional graduates were appointed. During the past twelve months there has been, for most of the time, one American assistant, the graduate native staff growing steadily to ten. The graduates have an opportunity to supplement their regular course in preparation for more responsible work in other hospitals and at the same time they have met a real need in taking over many of the duties formerly carried by the American staff. When the elective was changed, in 1925, to a regular, required two-months' course of public health nursing, there had been developed an exceptionally good correlation between clinics, hospital wards and home visiting, and to the extensive baby hygiene program there was added practical experience in two Turkish welfare associations.

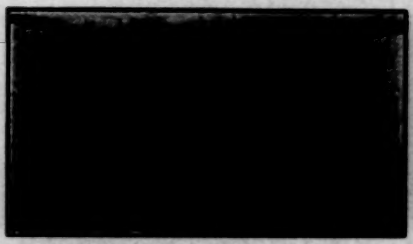
In the summer of 1927, Alwina

MARY K. NELSON, R.N.

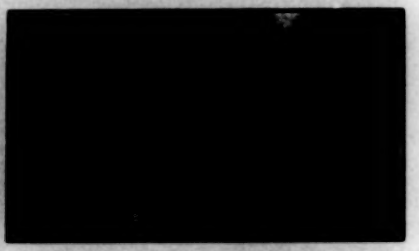
Francis, a Red Cross nurse graduated from the University of California School of Nursing, succeeded Miss Nelson as director of the school.

The largest number of students in the school at any period was fifty-eight in March, 1924. The present enrollment, seventeen, is the smallest since 1921. The unsuccessful effort to keep up the number of Turkish students enrolled is accountable for the gradual decrease. Because a very uncertain outlook was confronting the school in January, 1927, a new class could not be admitted. At the present time the school has on its roster six Turkish, two Armenian, two Bulgarian and seven Russian students. However, in a recent letter, Miss Francis states that fourteen Turkish and ten other students were admitted in the fall class. Fifty-four nurses have graduated, of whom six are Turkish, eleven Greek, ten Bulgarian, fifteen Russian and twelve Armenian.

Christiane Reimann, Secretary of the International Council of Nurses,



ARMENIAN STUDENTS DANCING IN NATIVE COSTUME



Turkish Students wear native costume at many social affairs. Seated at right is Esma Ibrahim, now a student at Teachers College.

writes after a recent visit to the school:

I was most impressed with what was being done in your school of nursing, and I feel very strongly that every effort should be made to continue the school for a year or two more. It exercises I think a still greater influence than you imagine, is widely influencing nursing developments in the south of Europe and is, I consider, one of the best schools of nursing in Europe at the present time. In Greece your four graduates carry the development of modern nursing, while in Bulgaria, two of the most prominent nurses are graduates of your school. All these women, whom I have met within the past two weeks, emphasized how much they owed to the training they received in your school.

Your Turkish graduates will naturally be those on whom the leadership in their own country will and should rest for some years to come both in hospital and in public health work. The high standards of your school, in the midst of surroundings lacking in modern systems of nursing seem to me to indicate the extreme importance of continuing it.

When the Medical School for Women Students of the American College for Women was closed by order of the Turkish Government, the institution ceased to be a medical teaching center, thereby losing one of its most powerful assets technically and financially. The withdrawal of the American Navy from Turkish waters lessened very greatly the number of patients, and gradually the character of the institution has changed.

Whether an American Training School for Nurses is needed now is still an open question. No one doubts the need of an American institution of some kind for the care of Americans requiring hospital care. This, of course, might be developed with a graduate staff. Certainly no one can deny that the school has been worth while. As a demonstration alone, it has been invaluable. The contribution made by American nurses to the development of this school is not easily measured, either in terms of words or in gold and silver. The three directors—Mrs. Rothrock, Miss Anderson and Miss Nelson, each rendered a high type of service to the school, and have exercised upon their students an influence that will carry on indefinitely. Graduates of the school are found scattered throughout the Near East and, wherever they go, they are carrying high the torch lighted by Florence Nightingale in the barracks at Scutari. As her true disciples they are penetrating the dark places of that great territory whose people from time immemorial have been without the kind of nursing care that only well trained nurses can give.

Concerning Charting

By Margaret Busche, R.N.

CHARTING is important for the following reasons: it is an organized picture of the patient, a logical development of the patient's progress; it records the events of the patient's illness in the interim between the doctor's visits so that he can use it in making a diagnosis, in determining the patient's progress or in deciding his course of action; it is "proof" of work done; it becomes a legal record in case of lawsuit; it is a time-saver for both doctor and nurses because if no written record is available, each person dealing with the patient has to be told separately about the case; it often becomes a scientific reference and an historical record.

In spite of the apparent importance of charting, it probably is one of the greatest "hates" of nurses. Many nurses complain that the time spent in charting might be more profitably used in actual bedside care. Is this not failing to recognise that adequate record keeping is a part of bedside care? Pride in records does not seem to be inherent in all nurses, and usually it has to be painstakingly cultivated. Charting is most difficult to teach; in the classroom, only the principles of charting can be taught. Actual charting on the wards, closely supervised, is the best way to teach this subject. Unless charts are adequate, there usually comes a day when someone goes to the patient's chart to find some fact and, like old Mother Hubbard's cupboard, it proves bare. This is unfair to the patient, as it might result in his getting a second medication or treatment when only one was intended, or in delay in diagnosis because facts necessary to establish a diagnosis are lacking; it is unfair to the doctor, because it does not give him a chance to make a proper interpretation of the patient's symptoms and progress; it is unfair to the hospital, because such lapses from accuracy on the part of the nursing staff are apt to cost the hospital in reputation and in money; it is unfair to the nurses themselves, because it robs them of their best evidence in case of argument over the treatment of a patient.

A discussion of the underlying principles of charting may be timely. It is noteworthy that there is very little available literature on the subject. How has the knowledge of it been passed from one generation of nurses to another? By word of mouth? It is true that many institutions now have ward procedure manuals which include specific charting rules. The advent of the manual has undoubtedly been a forward step in standardizing procedures and in promoting understanding on the part of all who are concerned in the care of a patient. Many young doctors now graduating from internships are purchasing copies of these manuals and taking them into their private practice. There is so very much to say about charting that it is easier to tell what to omit from a chart than to tell what to include on it. Maxwell and Pope say:

> Everything of any importance must be mentioned, but as clearly and concisely as possible, not using a single unnecessary word.

A big order! All of the texts in Nursing Procedures in use in our schools are more than brief in their treatment of charting.

Large letters, fancy letters or "backhanded" letters are not desirable in charting. Plain, easily legible,

small characters are needed. Printing is superior to writing.[1] Only standard abbreviations should be used. The reasons for this seem obvious, but hospitals still permit the use of some non-standard abbreviations which mystify all but the personnel of the particular hospital. All of the nursing texts contain abbreviation lists. Local expressions should be avoided, too. This is especially important if the chart is to be valuable as a legal and historical record. Doctors must coöperate in making these local expressions and non-standard abbreviations disappear, because the nurse is obliged to copy the doctors' orders verbatim. Poor spelling and ungrammatical language have no place on a chart. A small pocket edition of a good medical dictionary should be part of the equipment of every ward and of every nurse. Do not fill up the chart with useless, irrelevant material which helps to make a bulky thing to care for. Do not fail to blot the chart carefully after using ink.

Now, what to include in the chart? "Everything important!" (1) Time, always. Time *everything* occurs. This saves argument over alleged delay in carrying out orders. (2) All the patient's symptoms. It is impossible to tell, here, everything that should appear concerning symptoms. Great accuracy is needed in describing them. One should beware of making too compromising statements if one is not certain of the information being correct. It would be better to say "the patient *seems* better today" than to say "the patient *is* better today." On the other hand, indefinite or inaccurate statements are worse: "Patient complains of pain in stomach," when pain is in abdomen; or "patient complains of abdominal pain," when it could easily be said that "patient complains of sharp pain in right lower quadrant of abdomen." (3) The doctor's orders, copied verbatim. (Sometimes doctors write the orders directly on the chart.) As nearly as possible, the *reasons* for orders should be apparent. The very diagnosis may indicate this. However, suppose a patient is ordered "Aspirin gr. v" at 10 a. m. Would it not be well to record on the chart that at 9.30 a. m. the patient complained of a headache? The results of the orders carried out should also appear. Did the Aspirin relieve? If so, the statement should go on the chart. It is not always possible to get immediate results from treatment or medication, so that the statement of result may have to be postponed. A day's summary might contain a reference to the patient's appetite, if the patient were receiving a tonic. Reasons for orders, orders, and results of orders are very important in making a logical record. Definiteness is important here as well as in describing symptoms. If nourishment is ordered for 3.00 p. m., it is preferable to say "3.00 p. m.—tea and toast" rather than "3.00 p. m.—nourishment." (4) Intake and output (including defecation). It is important to chart these facts about all newly admitted patients, cardiac cases, kidney cases, post-operative patients and many others. *Accuracy* is the thing. Either c.c. or ounces may be used in recording the amounts. A 12- or 24-hour total in red ink is usually made, both on graphic sheet and bedside notes. Where the urine is involuntary, a check (√) or question (?) mark placed in the urine column should be explained in the remark column, otherwise it might appear that urine was lost or not measured. A great deal might be said about the methods and importance of intake and

[1] "Manuscript Writing," a little book by Marjorie Wise, is helpful.—*Ed.*

output recording. Greater inaccuracy probably occurs in recording it than in any other type of record keeping. (5) A record of the patient's rest and sleep. This is sometimes difficult to determine, because the patient says he did not sleep, when the nurse observes that he did. To avoid a discrepancy here the nurse can quote the patient on the charting of this point. A common practice among night nurses is to record the patients' rest for the night at midnight, because of the pressure of work in the early morning. This is not accurate and may lead to errors in statement which ruin the chart unless it is recopied, and this takes time.

The graphic or temperature sheet is often made to tell a great deal about the patient. It usually comes first in order on the chart and, as the doctor looks at it, he sees some important facts about his patient presented in the form of a graph. Principles of graph-making must be explained to students, or they may miss the point of spacing, dots, lines and their significance. Many people do not seem to realise that between each line on the graphic sheet the time is a definite period; if q. 4 h. temperature is being taken, it is four hours between lines. One may not, therefore, vary the spacing without ruining the plan of the graph. Dots should be connected with ruled and not free-hand lines. Besides temperature, pulse, and respiration, the graphic sheet often shows weight, chills, 24-hour total of intake and output, defecation, unusual treatment or medication, operation, etc. Some of these facts often help to explain rises in temperature.

There is a good deal of agitation nowadays about discontinuing bedside notes for all but seriously ill patients. It might be that the reduction of notes on convalescents would be a good thing; summaries on the graphic sheets are then the substitute for bedside notes. The writer feels that there are grave dangers, however, in the discontinuance of bedside notes. The result is apt to be an injudicious cutting down on bedside notes where they should be kept up. The doctor is often appealed to, with "We don't have to keep notes on her, do we?" This, in addition to other things, is poor psychology. Patients with notes discontinued may grow worse suddenly, or they may develop significant symptoms. If the charting is not begun again promptly, confusion results. In the hands of nurses with good judgment this practice of discontinuing notes might prove useful, but as a general thing, may it not have a bad result?

For some reason there is a good deal of criticism of nurses' charts being made, at present, by doctors. The doctors say that the nurses are failing to keep charts in home cases, one physician even relating that a nurse failed to keep a chart in a case of measles-pneumonia, because she didn't know whether "he wished one kept or not." Another physician claims that nurses frequently keep charts on scraps of paper, illegible even to the nurses themselves. One wonders what is the cause of this carelessness. Why should a nurse not feel the responsibility of keeping a chart in a home, as well as in a hospital? Should the registries take up this matter? Printed chart forms are available in most places and, if not, they can always be made by ruling off large sheets of paper.

Who gets this chart at the conclusion of the case? It should be offered to the doctor and, if he does not care for it, it is usually destroyed. If there is a widespread let-down in record

keeping on patients, it must be that we are failing to stress its importance.

There are so many things to be said about charting and so many examples of good and bad record-keeping that ought to be cited, that a paper on this subject cannot do more than take a bird's-eye view of the field. Has not the time come when the knowledge we have gained in charting up to this time should be collected in organised form, perhaps in a textbook?

Basal Metabolism

By Margaret C. Foley, R.N.

METABOLISM, resolved into its A B C's, is the building up and breaking down process that is constantly going on within the human body. Food is changed into living matter, living matter is burned into waste products, and when the thyroid gland, the seat of heat activity, is functioning normally, we use the proper amount of oxygen to support the body combustion at a normal rate.

It has been proved by pioneers in the study of metabolism that the amount of oxygen a patient actually breathes, under certain test conditions, is a direct index rate of metabolism. If he consumes a large amount of oxygen, he has a rapid combustion, a high metabolism; if he consumes a small amount of oxygen, he has a low combustion, a low metabolism.

The test conditions are that he be in a "basal" condition, that is, with the body at complete rest, the building-up and breaking-down process going on of itself without the stimulus from food, muscular activity, mental anxiety or apprehension.

One would expect age to have a definite bearing on metabolism and research has proved this to be true. The level of the metabolism varies greatly with age. During the first few days of life it is very low, then rises rapidly during infancy, and reaches its highest level between the ages of 2 and 6 years. Then it falls rapidly until the 18th year when the curve flattens out. Between the ages of 20 and 40 there is very little change, but after this a slight fall, so that by the 80th year the line is about 10 per cent below the average level for the age 20 to 40. There seems to be a stimulation to the basal metabolism during the period of growth.

Body Surface and Metabolism

THE heat production of a man depends largely on his size, but it is by no means proportional to the body weight. A large man gives off more heat than a small man, but for each kilogram of weight the small person has the higher metabolism. On the other hand, the metabolism of men of various sizes and shapes is rather closely proportional to the surface area of the body.

Eugene DuBois considered body surface and age the most accurate physiological factors to which to refer the metabolic rate of individuals. Women show an average basal metabolism about 7 per cent lower than that of men of the same age, and in considering the metabolism of women, the influence of menstruation should be considered. The rate in cases observed fluctuates up to a maximum of from 13 to 18 points. Literature contains

records of hyperthyroidism which is present only at menstruation.

Methods of Computing Basal Metabolism

FOR adults, children and those at the age of puberty, we have the modified DuBois standards, the Sanborn tables and the Benedict Hendry standard. Two methods of metabolism computations will not check exactly, unless the same "Tables of Normals" are used. Owners of Sanborn metabolism apparatus may use any table they wish. The apparatus or a similar design is immaterial, as far as this is concerned, as the original DuBois and Benedict standards are expressed in calories, although it is the oxygen consumption which is really measured.

Preparation of the Patient

1. The patient should retire not later than 10 o'clock the evening before the test.

2. Supper: 1 pint of milk, two slices of bread, no butter.

3. No breakfast, no drugs; a glass of cold water, an hour and a half before the test, will probably not alter the test.

4. A cold bath should *not* be taken on the morning of the test.

5. Smoking should *not* be permitted.

6. The patient should be at the metabolic room at 8 or 8.30 a. m. If in a hospital, he should be brought in a wheel chair.

7. All stiff and constricting garments, such as corsets, collars, belts, shoes, etc., should be removed and women should take out all hairpins and combs.

8. The patient should be directed to empty the bladder and the bowels, if necessary.

9. The machine should be explained to the patient, expressing clearly the harmlessness of the test, assuring him that he is to breathe pure oxygen or air.

10. Put the patient to bed lying on his back and make comfortable with pillows, as desired.

11. The rest period for a hospital patient should be from 20 to 30 minutes; for ambulatory cases, 30 to 60 minutes, depending upon the previous muscular activity. It is very essential during this period to secure absolutely complete relaxation, therefore it is necessary to prevent anything that will excite the patient, such as discomfort, noises, conversation, friends and visitors.

12. The temperature is taken before and after the test.

13. The pulse rate and respiratory rate should be taken after the patient is at rest in bed and several times during the test.

14. After the test is completed, the patient is weighed in as few clothes as possible. Then the height is taken in bare or stocking feet.

If the patient appears restless and apprehensive, a preliminary test for three or four minutes is carried out, and then a rest before the actual test is begun. All restlessness, nervousness, irregular breathing, swallowing, etc., should be carefully recorded. If the patient has appeared extremely restless, enough to cause a change in the basal rate, he should have the test taken at some future date.

The Sanborn Benedict apparatus has practically displaced the gasometer method and is used more widely than any apparatus in the world.

Why Tests Are Run for More than Five Minutes

BECAUSE defects can exist that would not be discovered in a five-minute period and errors that are made in readings for five-minute tests are twice as misleading as the same errors would be in a ten-minute test; for example, the machine could be run for five minutes without any oxygen at all used in the bell, but at the end of that time it would be very difficult to breathe. A ten-minute test under such conditions would be impossible.

Basal Metabolic Rates in Various Diseases

	From	To
Normal	+15	−15
Obesity	+10	−14
Cardiorenal without dyspnoea	+10	−10
Cardiorenal with dyspnoea	+25	+50
Nephritis with edema	+14	−40
Nephritis without edema	+ 2	+39
Pernicious anemia	+ 2	+33
Leucemia	+21	+123

	From	To
Prolonged undernutrition.....	−30	−10
Exophthalmic goitre:		
1. Very mild.....	+15	+30
2. Mild.....	+30	+50
3. Severe.....	+50	+75
4. Very severe.....	+75 above	
Cretinism and myxedema....	−40	−15

Hyperthyroidism includes those diseases of the thyroid gland in which there is an excessive secretion of thyroxin, with an increased basal rate, tremors, sweating, tachycardia, muscular weakness, loss of weight, feverish mental activity.

Hypothyroidism includes those diseases of the thyroid gland in which the thyroid secretion is deficient, the metabolism of the body is depressed and the heat production is at a low ebb. In the young, youth is lessened and the skeletal system is dwarfed. The skin is dry and thick; the hair coarse and shows deficient nourishment; and the mentality does not rise above the level of the infant or the child.

Limits of the Basal Metabolic Rate

IN 1924, at Mayo Clinic, the highest rate that had been recorded was plus 172. The lowest was minus 40, taken in a Boston Hospital on a young girl from Holland whose case they were trying to diagnose.

Conclusion

IN conclusion care must be taken, in thyroid cases, to ascertain the presence of complicating conditions which seriously affect the metabolic rate. For example, diabetes has been a rare complication of hyperthyroidism or vice versa. These are points that must be ascertained by the doctor. Simple infections giving low degrees of temperature, as fevers, result in a marked increase in the metabolic rate. Apprehension and anxiety play a big part in having unreliable data in basal metabolism rates and it is here that the quality of the nurse's service shows most clearly.

When all the factors spoken of can be eliminated and the basal metabolic rate can be regarded as a true index of thyroid activity, it may be said that, in a clinic for diseases of the thyroid, a test of the rate of basal metabolism is an invaluable factor in the data for diagnosis, that it aids greatly in prognosis, that it probably has great value in determining the results of treatment in any case.

More Rural Hospitals

BELOIT, Kansas, and Wauseon, Ohio, have been selected as locations for the fourth and fifth rural hospitals in the series which the Commonwealth Fund is helping to build as a contribution toward the improvement of health and medical conditions in country districts. Three such hospitals have already been awarded to Farmville, Virginia; Glasgow, Kentucky; and Farmington, Maine; under a coöperative program whereby the fund donates two-thirds of the cost of construction and equipment while the local community guarantees the remainder and undertakes the expense of operation. Fifteen applications from nine states were carefully studied by the rural hospital division of the fund before Beloit and Wauseon were given the awards. The program contemplates the placing of these hospitals in rural areas where they will serve a surrounding district with a radius of approximately thirty-five miles.

"THE formation of character goes on apace regardless of teachers or schools. The question is, How can school work contribute most to the making of the good citizen?"—*James E. Russell.*

History of Nursing Maps

By Lena Dixon Walker, R.N.

THE accompanying photograph shows a very interesting piece of work done by the Freshman class of Aultman Hospital, Canton, Ohio, in History of Nursing. The silhouette represents the first training school in each state with the name and date below. Letters were written to the State Boards of forty-eight states, asking for the name of the first training school in the state. In many instances considerable research and correspondence were required to establish the priority. For instance, the letter to Alabama was forwarded to the State Board of Health which could give the names of the early hospitals but not those of the training schools, so from this list of hospitals went more letters to learn the date of the establishment of their schools. New Hampshire and Virginia presented equal difficulties. They were unable to learn of any accredited training schools in Nevada.

In all of these letters they asked for any additional information concerning the history of nursing in each state, knowing that the general histories are brief. The response to this came in the form of letters, training school booklets, senate bills and other interesting material. Louisiana sent a copy of an interesting address given at the Institute of the State League of Nursing Education; the State Examiner of Missouri trusted them with her personal copy of the History of Nursing in Missouri, giving a most interesting account of the work done by the Jesuits and Sisters in the eighteenth century and laying the foundation for the first hospital west of the Mississippi. All of these data have been carefully filed; they make a book more interesting than any fiction, and give an appreciation of the work done by those courageous men and women who made the history of nursing in the United States. From many of

these first training schools came pictures, photographs, snapshots, etc., of their first hospital, and the album containing them is the most popular book in the hospital library. They would have enjoyed making a silhouette of each of these, but it would not be practicable.

Seeing the work done by the Freshmen, the preliminary class set enthusiastically to work to make an illustrated map of the "Development of Medicine and Nursing in Europe." This map would not photograph well, since the figures used to represent the various phases of medicine and nursing were too small. This map required much time and research and they received splendid coöperation from Ambassadors of various countries, the American College of Surgeons Research Library, and several Ohio doctors who had done recent postgraduate work in Europe.

They were unable to obtain any information concerning Russia, either in medicine or nursing, and they have that large space with only Eli Metchnikoff and his theory of phagocytosis. At Scutari is a little lamp; in northern Greece, a caduceus, in Belgium and France are the markers for Edith Cavell and Jane Delano, who are now, however, buried in their native lands; in Delft, Holland, is a microscope; and at Folkstone, England, is a heart (not a valentine!); in Geneva is a red cross; in Germany is, of course, Kaiserswerth; and Italy has a Riva Rocci sphygmomanometer. Finland has a lot of little ships sailing in to attend the International Council of Nurses in 1925. Each country has many interesting illustrations showing the growth of nursing and medicine down through the centuries. The map was extended to the south to take in the Mediterranean Sea, so that they might have the Star of Bethlehem and "Inasmuch as ye did it unto the least of these, ye did it unto me."

Schools of Nursing Indicated on Maps

Alabama	Providence Hospital	Mobile	1905
Arkansas	Sparks Memorial Hospital	Ft. Smith	1908
Arizona	St. Joseph Hospital	Phoenix	1910
California	Children's Hospital	San Francisco	1890
Colorado	Denver General	Denver	1886
Connecticut	New Haven Hospital	New Haven	1873
Delaware	Homeopathic Hospital	Wilmington	1903
District of Columbia	Garfield Memorial	Washington	1889
Florida	St. Luke's Hospital	Jacksonville	1905
Georgia	Telfair Hospital	Savannah	1893
Idaho	St. Alphonsus Hospital	Boise	1905
Illinois	Cook County Hospital	Chicago	1880
Indiana	Indianapolis City	Indianapolis	1883
Iowa	Jane Lamb Memorial	Clinton	1889
Kansas	Christ's Hospital	Topeka	1892
Kentucky	J. N. Norton Memorial	Louisville	1881
Louisiana	Charity Hospital	New Orleans	1894
Maine	Maine General	Portland	1894
Maryland	Johns Hopkins	Baltimore	1889
Massachusetts	New England Hospital for Women and Children	Boston	1872
Michigan	Harper Hospital	Detroit	1894
Minnesota	St. Barnabas Hospital	Minneapolis	1894
Mississippi	Natchez City	Natchez	1898
Missouri	St. Louis City	St. Louis	1895

Montana	St. John's Hospital	Helena	1905
Nebraska	Bishop Clarkson	Omaha	1887
Nevada	No accredited training school		
New Hampshire	Margaret Pillsbury	Concord	1888
New Jersey	Paterson General	Paterson	1881
New Mexico	St. Joseph Sanitarium	Albuquerque	1902
New York	Bellevue Hospital	New York	1873
North Carolina	Rex Hospital	Raleigh	1894
North Dakota	Grand Forks Deaconess	Grand Forks	1904
Ohio	Huron Road Hospital	Cleveland	1883
Oklahoma	All Saints Hospital	McAlester	1898
Oregon	Good Samaritan	Portland	1890
Pennsylvania[1]	Pennsylvania Hospital	Philadelphia	1883
Rhode Island	Rhode Island Hospital	Providence	1882
South Carolina	Roper Hospital	Charleston	
South Dakota	Sioux Falls Hospital	Sioux Falls	1902
Tennessee	Nashville City	Nashville	1879
Texas	John Sealy Hospital	Galveston	1897
Utah	Holy Cross	Salt Lake City	1901
Vermont	Mary Fletcher	Burlington	1882
Virginia	Marshall Lodge Memorial	Lynchburg	1886
Washington	Tacoma General	Tacoma	1882
West Virginia	Hinton Hospital	Hinton	1891
Wisconsin	Marquette University	Milwaukee	1890
Wyoming	Laramie Memorial	Laramie	1891

[1] "The date of the first school in Pennsylvania has always been claimed by the Woman's Hospital of Philadelphia as 1872, the year when nurses were first trained in that institution. It is not so stated in the History of Nursing, probably because of some technicality in organization." See "A History of Nursing Scrap Book," *American Journal of Nursing*, April, 1927.—Ed.

Six Questions and Answers on Grading

By May Ayres Burgess

1. Why should nurses be asked to contribute more money than anybody else towards the support of the Grading Committee?

They weren't asked! But they are giving more, because they have more at stake than anybody else. It is their profession which is being studied. The Nurses' Committee for Financing the Grading Plan was not formed at the request of the Grading Committee; it is a voluntary organization of the nurses themselves. It is conducting a campaign to raise money because it wants to be sure that all the facts instead of opinions about nursing shall be available; and fact-gathering is extremely expensive.

2. What will it profit nurses in the end?

It hopes to make at least a beginning along four lines:

(a) To give nurses a clear picture of what is happening in their own profession.

(b) To help private duty, public health, and institutional nurses to understand each others' problems, and show them how to work together with intelligence and sympathy towards solutions.

(c) To assist hospital trustees and administrators to recognize the difference between nursing service and nursing education, and to decide what their responsibility is towards each.

(d) To interpret modern nursing problems to the members of the medical profession, helping them to supplant unreliable opinions with definitely ascertained facts, and making it possible for nurses and doctors to discuss plans for the future, frankly and constructively, on a friendly professional basis of mutual understanding.

3. By whom will changes be administered or urged—by the group which has paid most? What assurance is there that the advice or opinions of nurses will be accepted?

Everyone is free to advise or recommend, but only nurses can administer reorganization in nursing. Outsiders are helpless. The Committee on the Grading of Nursing Schools cannot directly bring about a single change in the nursing profession. It has no enforcing power whatsoever. The Committee can gather facts, make them known, and offer suggestions based upon them; but at that point it must stop. *Any important reforms in the nursing profession must be brought about by the nurses themselves.* The facts which the Committee gathers will be of value only if the nurses use them in their own work. The popular interest and understanding which the Committee awakens will be lasting only if the nurses are alert enough and intelligent enough to keep it alive. The Committee is helping gather the ammunition and the allies, it might even furnish the flags, but the campaign must be conducted by the nurses themselves.

4. How much has each organization contributed so far?

Contributions and pledges are as follows:

American Nurses' Association	$7,000
National League of Nursing Education	5,000
National Organization for Public Health Nursing	5,000
American Medical Association	5,000
American Hospital Association	500
American Public Health Association	1,000
Mrs. Chester Bolton	15,000
Rockefeller Foundation	25,000
Commonwealth Fund (subject to annual confirmation)	20,000
Nurses' Committee for Financing Grading Plan (Nov. 10)	21,368
Total	$104,868

This includes $26,500 contributed in 1925 and 1926 for the purpose of establishing a central office and planning a program, of which about $15,000 was left over; $78,368 has been contributed or pledged in 1927, which leaves a little over $106,600 still to be raised on the $200,000 budget.

5. When will the facts on supply and demand be published?

If possible they will be printed in a monograph ready for sale at the Louisville meeting in June.

6. When will grading start?

The preliminary work was started months ago. The statistical preparations necessary for this project are the most difficult contemplated by the Committee; and experimental work covering perhaps several months remains to be done before it will be considered safe to send the questionnaires out into the field. The Committee has had to choose between having the first grading this winter, as was originally planned, and going ahead with the supply and demand monograph. It decided that if the supply and demand studies were dropped now, it would be very difficult to resume the work later. There is strong and widespread demand for the immediate publication of the supply and demand monograph, especially in relation to private duty nursing, whereas most of the schools are much interested in grading, but rather glad to have a few months longer in which to prepare before it comes. The first grading was planned for this winter and the first monograph for next winter. The Committee recently voted to meet popular demand by pushing the monograph forward six months, and holding the grading back for about the same length of time. It is hoped that the experimental work will be finished in the late spring, and the actual questionnaires will go out to the schools shortly thereafter.

Prevalence of Poliomyelitis in the United States

REPORTS of poliomyelitis for the week ending October 15, 1927, showed a decrease of 12 per cent in the number of cases as compared with the preceding week. Forty-four states reported 579 cases of poliomyelitis for the week ending October 15, 660 cases for the week ending October 8, and 635 cases for the week ending October 1.

Public Health Lectures in Baltimore

How a Group Plan Has Been Established Which Brings Together Pupil Nurses of All Hospitals in the City

By V. L. Ellicott, M.D.

THREE years ago, the City Health Department received a number of requests from hospital superintendents, asking for lecturers to give their pupil nurses the lectures on Public Health recommended by the National League of Nursing Education.[1] The Health Department was called upon, apparently, because of the recommendation of the League that the lectures be "conducted by physicians with board-of-health experience."

As Baltimore has fourteen hospitals with training schools, it was obvious that we could not comply with the increasing requests for lecturers; it was poor efficiency, moreover, to send lecturers to one hospital after another to repeat the same lectures when one series of lectures to a combined group would be just as satisfactory. The trying out of a single series was, therefore, indicated and was placed under the writer's supervision.

Preliminary Arrangements.—The first step in starting the plan was the holding of a conference of training-school superintendents on January 5, 1925. This conference was followed in a few weeks by two preliminary or experimental lectures which were attended by about 200 nurses from seven or eight hospitals. As the experiment proved successful, a regular course was planned for the following fall.

[1] Standard Curriculum for Schools of Nursing, fifth reprinting, 1924, page 67. (In the revised curriculum the outline, "Elements of Sanitary Science," which this course approximates, may be found on page 178. It is to be noted that it is *not* a course in public health *nursing*.—Editor.)

The Course in 1925

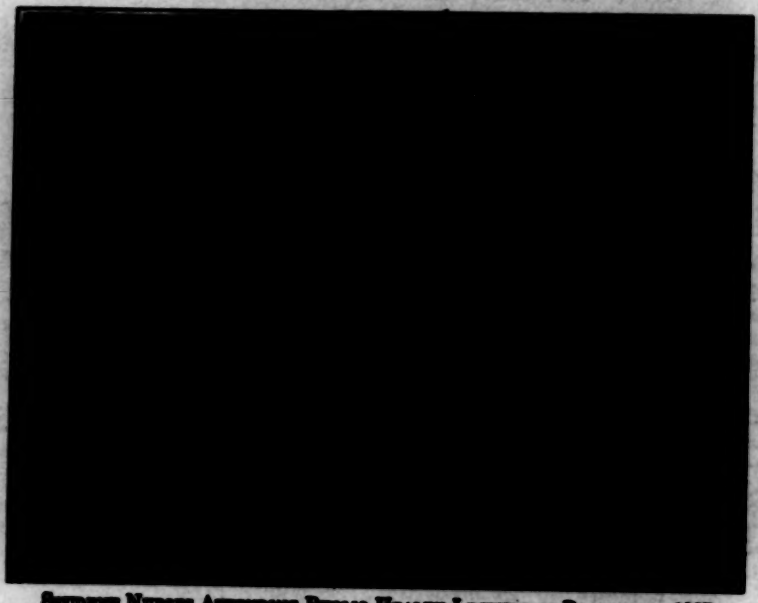
Meetings.—During the first year, 1925, the course consisted of ten lectures on the following subjects:

1. History
2. Sewage Disposal
3. Water Supply
4. Food
5. Ventilation
6. Housing
7. Industrial Hygiene
8. School Hygiene
9. Vital Statistics
10. Administration

The outline followed was that given in the Standard Curriculum referred to. The nurses met in the Health Department assembly room, the location of which is fortunately in the central part of the City, on Tuesday evenings from 8.00 to 9.00 p. m. from October 6 to December 8. All arrangements were made by the epidemiologist with the assistance of the Bureau of Nursing.

Attendance.—Ten out of the fourteen hospitals having training schools sent the nurses of their senior classes and the average number present was about 250. The attendance was kept by giving each nurse a card at the door of the lecture room, the nurse signing the card and giving it to her superintendent the following day.

Lecturers.—Lecturers were chosen from the staffs of the Johns Hopkins School of Hygiene, Johns Hopkins University, the City Health Department, and the State Health Department. The lectures were given without compensation. The atmosphere established was like that of a course of instruction rather than a series of formal lectures. Lecturers were asked to present their material in a simple but emphatic way and on account of the limited time, to attempt



STUDENT NURSES ATTENDING PUBLIC HEALTH LECTURES IN BALTIMORE, 1927

to cover only a few of the more important aspects of their subjects. Lantern slides were used by most of the lecturers and did much to overcome the psychological difficulty of the nurses in picturing the work of an unfamiliar field.

Material.—As we did not wish to make the course difficult by requiring outside reading and as it was not feasible to ask the nurses to take notes while a lantern was frequently in use, we gave out notes in the form of mimeographed abstracts of each lecture, mailing after each lecture enough copies for each superintendent to give each nurse a copy.

Examination.—A written examination was held at the end of the course, the questions being made up at the Health Department and mailed on mimeographed sheets to the hospitals. The taking of the examination was optional with each hospital superintendent; 214 nurses took the examination in 1925. Though each group of nurses was examined in its own hospital, all the papers were sent to the Health Department for marking. Thus the standing of the different hospitals was compared on an equal basis and had the effect of introducing a spirit of rivalry, as indicated by a rise in the average grades from 72.8 in 1925, to 89.8 in 1926.

MODIFICATIONS IN COURSE

Outline of Course.—After the first year, the number of lectures was increased from 10 to 12, so as to include a lecture on infant welfare, one on communicable diseases, and a miscellaneous lecture on the prevention of certain non-infectious diseases, mental hygiene, health insurance, etc. To provide the necessary time, the lectures on ventilation and housing were combined into one lecture. The

course was further enlarged to include a demonstration visit to the Health Department and quizzes between the lectures held in the various hospitals, the total number of hours, including the examination, thus reaching 15, making the course equivalent to one college credit.

Material.—After the first year, instead of giving the nurses abstracts of lectures, a supply of questions and answers were given out, each consisting of one sheet of questions and one sheet of answers.

Attendance.—In the second year, all of the city hospitals sent their nurses. Approximately 265 were present at each lecture. To provide sufficient space, the lecture room of the War Memorial Building was obtained.

Records of attendance were kept by supervising nurses, one of whom was sent by each hospital to take charge of her own group.

Future Plans.—For the course given this fall, the plans were practically the same as those of last year. An additional lecture will be given on the subject of Communicable Diseases, in order to familiarise the nurses with the subject which we consider more important to them than any other. The two lectures on water and sewage will be combined to make place for the additional communicable disease lecture. As soon as possible, the abstracts and quiz questions will be published in the form of an inexpensive textbook and distributed to the nurses.

Judging by the general acceptance of the plan, the course will be continued indefinitely in the future.

Radiographic Examination

Method of Preparing Patients as Practised at the Charles T. Miller Hospital, St. Paul, Minn.[1]

Gastrointestinal

ALL patients for gastrointestinal examination will have one-half to one ounce of cereal, six hours before examination. Patients should not have breakfast or lunch (except when specified) the day of the examination.

Kidneys

ALL patients for the examination of the kidneys will have oil, as above, in the evening, with s.s. enemata in the morning and fluid diet until they have reported for examination.

Spine

ALL patients for the examination of the spine (lower dorsal or lumbar) will have oil, as above, in the evening, s.s. enemata in the morning and fluid or soft diet until they present themselves for examination.

Colon, Hips, Pelvis

ALL patients for the examination of the colon, hips, joints, or the pelvis, will have oil, as above, in the evening, and s.s. enemata in the morning and present themselves for examination.

[1] This hospital is one of four which cooperate in providing nursing experience for the Minnesota University School of Nursing.

Deep Therapy

ALL patients for treatment (deep therapy type) will report for the same *without* a lunch of regular diet on the day they report for treatment, *i.e.*, lunch must be light.

General Instructions

ALL requests for X-ray examinations will be filled out on the cards, signed by the attending physician, and presented at the X-ray room immediately following. Those filling in the data will take care to note specifically the part to be examined, as right forearm, upper one-half or lower one-half, or right arm, lower one-third, etc.

Requests for examination of the chest will state whether the information desired is for conditions in lung tissue or the mediastinum, as the regular plate examination by either single or stereoscopic plates will give little or no information concerning conditions in the mediastinum.

Preparation for Gall Bladder Radiograms

EACH patient is allowed a light meal at 6 o'clock in the evening. Starting at 9 o'clock he takes two iodeikon capsules, Swan-Myers, with a half glass of water every fifteen minutes until all the capsules are taken.[2] The patient is requested to remain as much on the right side during the night as possible and the first film is made at approximately 9 o'clock the next morning. He is then allowed a breakfast of cereal with cream to empty the gall bladder, and the second picture is then taken.

[2] In patients weighing less than 135 pounds, eight capsules are usually sufficient.

It is especially important that on the morning in which the pictures are to be taken the patient be shut off from all appetizing odors of food, especially that of broiled or fried meats. The gall bladder responds markedly to psychic influences and is quickly emptied by the smell or thought of tempting foods. Many pictures have been spoiled by the lack of attention to this detail. The gall bladder has emptied and a shadow is not obtainable.

Diphtheria Prevention

THERE are two main objectives in the diphtheria prevention campaign:

1. To Schick-test those children who received their toxin-antitoxin treatments six or more months ago. Some children are not made immune with a single series of injections and need further treatment. The Schick test will tell accurately whether protection has been developed.

2. To give toxin-antitoxin to children, most especially young children, who are most susceptible to diphtheria, who have not as yet been protected.—*Detroit Weekly Health Review.*

Uruguay

THE "Dr. Carlos Neri" School for Nurses.—Since her return to Uruguay, Miss Adami, international graduate 1923-24, has filled the post of directress of the "Dr. Carlos Neri" School for Nurses in Montevideo. Practical work for the nurses has been arranged in the *Pereira Rossell* Hospital, in the Polyclinic and Children's Surgical Hospital, in the maternity and gynecological buildings, the military hospital and in the various services of the Casa del Nino child welfare organization. A National Association of Nurses has been founded, and a nursing library is also being formed.

Manual Breast Expression

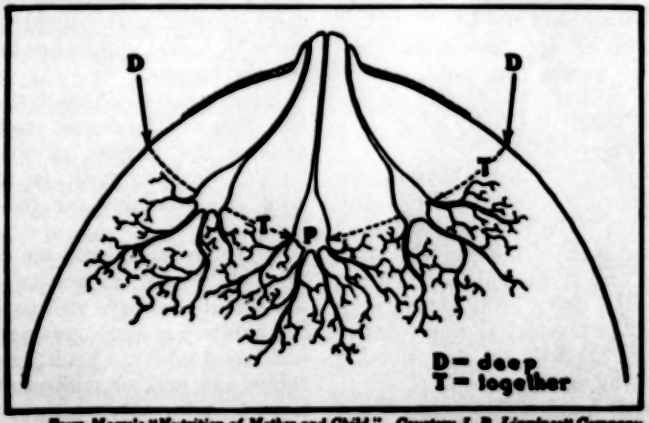
The Importance of Teaching It to the Mother

By Carrie Hunt McCann, R.N.

IF every baby were normal and the mother had normal breasts, with a normal supply of milk and a good supply of mother instinct, one might get along very well without any scientific knowledge of manual breast expression. But for the premature baby, the little sleepy baby that does not nurse well, for the inverted nipple, for the cracked nipple, for the over-abundant supply of breast milk, for the inadequate supply, and for the thousand and one complications that may arise in breast feeding, manual breast expression is often an ever present help in time of trouble. How often has the mother watched, with tears in her eyes, her milk supply slowly decrease, when the baby who was too weak to nurse well did not stimulate the breast enough to keep up the supply. Or, to her dismay, she has found when she puts the little baby, who has been ill for a few days, back to her breast, that her milk is gone.

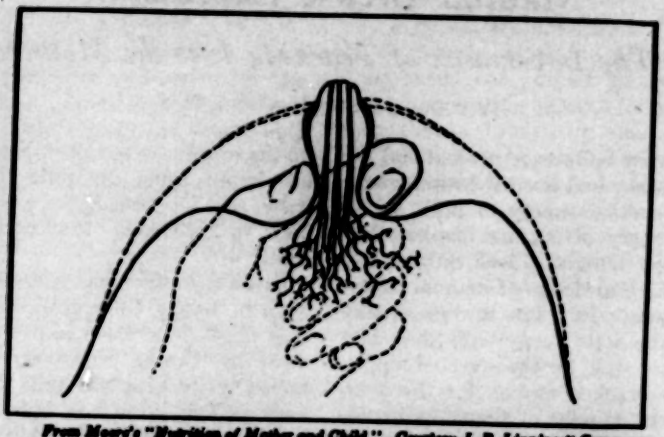
Often a mother has suffered many days or weeks from cracked nipples that might have been healed in a few days by taking the baby off the breast, expressing the milk by hand and feeding it to the baby with a bottle. The mother with the over-abundant supply of breast milk can easily strip off the thin, watery milk which comes first, and give the baby the creamy milk which comes last. This also relieves the danger of the milk decreasing from the breast not being drained.

The mother with an inadequate supply may increase the milk by



From Moore's "Nutrition of Mother and Child." Courtesy J. B. Lippincott Company

Fig. 18.—Illustrates the movements needed to force milk out of the little pockets "P" in which it collects. Place a finger and a thumb on opposite side of the nipple at "D" and "D". Press deeply into the breast in the direction of the black arrows. Then compress the breast together in direction of the dotted line toward point "P". This will force the milk out of the ducts in streams. "Deep" and "together" express in two words the motions required.



From Meara's "Nutrition of Mother and Child." Courtesy J. B. Lippincott Company

FIG. 19.—Diagram showing the method of expressing the milk from the breast by compressing the milk pockets between the thumb and forefinger. The three unused fingers may be folded as indicated or used to support the breast. This represents the second or "together" motion.

breast expression. Sometimes when the baby is three or four months old, his mind has developed so that he notices every new object, and at every sound he may stop nursing to look around. The mother, ignorant of the cause, decides that the breast milk is inadequate or not nourishing, and instead of testing the milk, as she could do with manual breast expression, she weans the baby or gives a supplementary feeding.

The women in Europe have known about breast expression for many generations. The husbandman knows the importance of milking the cows regularly and thoroughly. Even the child on the dairy farm understands this, and the mystery is why this has not been applied to our nursing mothers long ago.

The little hand breast pump is not at all satisfactory. In the hospital the Abt's breast pump, no doubt, can be used very well, but the cost would prevent its use in most homes. Notice the baby nursing, how he takes a deep and together motion with his lips. This we try to imitate as nearly as possible with the thumb and finger in expressing the milk. If it is done correctly, there can be no danger of hurting the breast. How many more babies might have mother's milk if every mother were taught the principles of breast expression before she left the hospital!

Every nurse could teach the mother the care of the breast, just as she teaches the technic of the baby's bath. Mother's milk is as necessary as cleanliness for the healthy baby.

In connection with teaching the manual breast expression to the mother, it is always well to check on her habits, her sleep, rest period, diet and liquid intake. Fruit, green vegetables and milk or milk products are important for every nursing mother. Many nursing mothers, especially in the foreign home, would not hesitate to take any active cathartic which she may have at hand, yet she will refuse the mildest of fruits, lest the baby have a colic.

Identification of Newborn Infants

"HOW can I be sure that my baby will not be mixed up in that big nursery?" The question is inevitable and none should be answered with greater care, sympathy and understanding than this of the incoming maternity patient. Upon the care with which it is answered, and the technic of the identification procedure explained, hangs the peace of mind of the mother until such time as the child shows unmistakable evidences of its parentage.

The methods for rendering "assurance doubly sure" are varied, although the Deknatel nursery name necklace, devised by the late Dr. Morgenthaler of the Brooklyn Hospital and long in successful use at that institution, seems to take precedence over any other. St. Ann's Maternity of Cleveland, like the Brooklyn Hospital, puts reliance on this method alone and has the sterile necklace sealed on before the cord is cut. At the Long Island College Hospital, it is said that only once in seven years has a nurse forgotten to put on the necklace and that omission was immediately noted by the nursery head nurse. The Strong Memorial Hospital of Rochester, where the maternity service is still small, reports its dependence on the necklace but states that it is not applied as a sterile procedure before the cord is cut but is put on while the baby is being weighed and measured.

The Columbia Hospital of Milwaukee has a triple method of identification consisting of the necklace, the baby's footprints, one impression made on the chart and a duplicate on a special slip which is given to the mother, and an X-ray of the baby which is made before it is taken to the nursery. The X-ray is done, primarily, to ascertain if there is a deformity, a fracture, or an enlarged thymus, but it also serves as a means of identification.

New York Nursery and Child's Hospital uses the necklace and also takes the mother's finger print and the baby's footprint in the delivery room. These are placed on the back of the labor sheet of the mother's chart. This hospital was one of the first to use the footprint method and states:

Its use is continued entirely for the psychological effect. The foot of a newborn infant has not developed the whorls and ridges upon which the science of finger prints depends. The creases are probably peculiar enough to decide within two weeks' time which of two infants belongs to a given set of prints, however it is purely on the basis of photographic resemblance and without scientific basis.

Boston City Hospital uses the necklace, the finger and footprints and adds the further precaution of a name tape of adhesive applied to the wrist. At the New Coleman Hospital in Indianapolis (part of the university group) the necklace identification is supplemented by the taking of footprints.

Sloane Maternity of New York has a name tape affixed to the wrist of the mother on admission. Before the cord is cut, a necklace with corresponding name is sealed on the baby's neck. In this hospital the babies are kept in a warm crib in the delivery room for one hour before going to the nursery. During this time the supervisor of the delivery room sends a card with the essential data regarding the birth to the office. Immediately upon arrival of the baby in the nursery, that supervisor makes out a slip, quite independently, which is sent to the office and checked with that from the delivery room. If for any reason a necklace has to be removed, it is done under the direction of the superintendent of nurses or one of her

RECORD USED AT UNIVERSITY HOSPITAL, MINNEAPOLIS

assistants and the necklace is reapplied to a wrist.

The University of Minnesota has footprints of baby and thumbprints of mother made in the birth room. In the nursery, duplicate adhesive tags are made out. On these are noted name, sex, time of birth, date and hospital number. One of these is placed on the crib prepared for the baby and the other is taken to the delivery room and is applied on the baby's neck before removal to the nursery. A slip is sent to the Pediatric Department with information on the following points: date, name, sex, time, temperature, condition, tubbed, mother (multipara or primipara), character of the delivery and information on the passage of meconium and urine.

Identification wrist bands are used at Harper Hospital, Detroit, Mich., in marking new babies.

The method has been in successful practice for many years. The bands are made of one-quarter-inch cotton tape wound closely with

IDENTIFICATION WRIST BAND

two by one-and-a-half-inch adhesive. The adhesive should cover the tape three times. One winding is not sufficient, as the adhesive is apt to become moist and come off the tape. The baby's name is printed on the adhesive tape with indelible ink while the baby is still in the birth room. *No baby is removed from the birth room* until the name tape has been put on its left wrist. This is done with the supervision of the birth room supervisor. The tape is tied on the wrist and then further secured by sewing. Wrist bands are inspected daily at the time of bathing and a notation made of them in the nursery notes. If it is necessary to remove and renew a wrist band, it is done under supervision of the nurse in charge. Each infant is identified by the wrist band before taking it to its mother and before its treatments are administered. Mother's bed is marked with a name card.

The Maternity Hospital of Cleveland has a system of name tags and number tapes that gives satisfaction. The name tags are:

1. Square of sterile adhesive containing baby's name, sex of baby, tape number, time of birth, date, doctor who delivered, supervisor—for back of neck.

2. Small strip of sterile adhesive containing name—for baby's leg.

These tags are kept sterile and are written by supervisor in the delivery room after the baby is born.

Procedure for Marking Babies

Number Tape.—As soon as the baby is born, this tape is tied on baby's arm by obstetrician, who reads number aloud as he passes duplicate to non-sterile nurse.

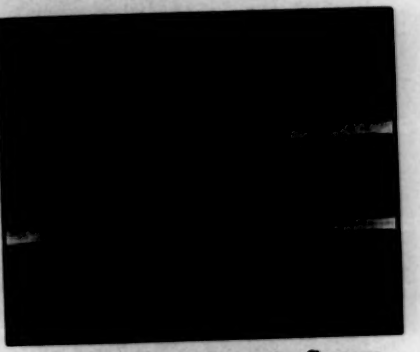
Number Tape (duplicate).—Tied on mother's wrist by the non-sterile nurse, who reads number aloud as she receives tape and immediately records number on labor sheet.

Name Tags.—Properly filled out, put in position by sterile nurse—the square tag between the shoulders, the narrow tag on side of baby's leg, just below knee.

Note.—Nurse-in-charge is held responsible if baby is removed from delivery room before all of these tags have been attached. Any nurse finding a baby without these marks of identification must notify supervisor at once. Supervisor must report same to superintendent.

It is the duty of the nurse who gives the first bath to compare the tape on the arm with the tag on the back. When the baby is shown to the mother, after going to the floor, the nurse draws her attention to the number tape on her wrist and the one on the baby's arm and draws down the neck of the dress so that she may read the tag there.

"This hospital," says Georgia Hukill, the Director of Nursing Service, "places the mistake of taking a wrong baby into a mother's room in the same category as giving a wrong medicine to a patient, and insists upon as much exactness in carrying out that procedure." The nurse reads the baby's leg tag and compares it with the name on the crib, before taking the crib from the nursery. Then, as she enters the mother's room with the baby, she calls the name and waits for her answer before taking the baby from the crib. The leg tag and crib card are again compared before the baby is returned to the crib after nursing.



Initials are Always Added for Common Names Like This

The methods used at the Pasadena Hospital for the identification of newborn infants are as follows, writes Mildred Newton, Obstetrical Supervisor: the Deknatel nursery necklace, footprints, mother's finger prints, and measurements.

After the mother has been taken to the delivery room, the necklace is completed by the nurse in charge, boiled, and placed on the instrument table. Under no circumstances is it permissible for the necklace to be put on the table before the mother is actually in the room, as there is too great a danger of an emergency case coming in and using the room prepared for another patient. The necklace is sealed around the baby's neck by the doctor or sterile nurse, preferably before the cord is cut. If this is not possible, it is done before the baby leaves the delivery table. In case of an emergency delivery, where there is no time to prepare the necklace, it should be formed and sealed on, before either the mother or baby leave the room. In no case does a baby leave the delivery room, nor can it be admitted to the nursery, without this identification.

If there is a Mrs. Mary Smith in the ward, and a Mrs. Dorothy Smith is admitted, the initial of the second mother's given name is placed before the surname on her baby's necklace. In such a case it is well to make a new necklace for the first baby with its mother's initial included, change the necklace in the mother's presence, and explain to her the reason for so doing. This gives her an increased confidence in the method of identification, and thereafter the babies are

designated on all reports and orders as Baby M. Smith and Baby D. Smith.

The necklace is read aloud to the mother when the baby is placed at the breast, eliminating the possibility of giving the mother the wrong baby. When the baby is dismissed, the necklace is either cut and removed in the mother's presence, or it may be kept, on the receipt of one dollar. As the actual cost of the beads is about sixty-six cents, this makes the system pay for itself after the initial cost is met. Necklaces not kept may be boiled, and the beads re-strung, the only cost to the hospital in such a case being the very small sum for the new cord and lead seal.

In addition to the necklace, the baby's footprints and measurements, and the prints of the first three fingers of the mother's right hand, are taken before they leave the delivery room. One copy of these is placed on the Newborn Record of the infant's chart, the other being given to the mother. While the specially prepared ink, glass plate, and roller, give the ideal method for taking footprints, an ordinary stamping pad with black indelible ink will furnish quite a satisfactory, inexpensive outfit, costing about one dollar.

After trying both the methods of marking the babies with adhesive tapes and labels, and with the bead necklaces, there is no comparison between the real sense of safety which the latter gives the mother and the nurse. Adhesive strips blur easily, and are so apt to slip off of a tiny wrist or ankle or become detached from the back, that they seem an imperfect method of identification to be used during a two weeks' stay in a hospital nursery. The measurements are of the least value in this system, but the footprints which do not change during infancy, and which differ as widely as do fingerprints, furnish an additional permanent record of identification, which is made even more valuable by the addition of the mother's fingerprints.

The Johns Hopkins Hospital finds that the necklace applied to the baby's ankle is an adequate and wholly satisfactory method which avoids an occasional difficulty, that of a slight skin irritation, which sometimes occurs when the necklace is used around the neck.

Even a small study of this problem reveals not only a high degree of efficiency in the procedures adopted by the various institutions, but also a very sympathetic attitude toward each anxious mother who asks, "How can I be sure that I shall have my very own baby to take home?"

Committee on the Grading of Nursing Schools

PASSED THE FOLLOWING RESOLUTIONS AT ITS ANNUAL MEETING NOVEMBER 29, 1927

1. Resolved: That the Committee on the Grading of Nursing Schools express to the members of the nursing profession throughout the country its sincere appreciation of their expressions of confidence and their active cooperation as shown through their generous contributions to the fund now being collected by the Nurses' Committee for Financing the Grading Plan. Resolved further, that special thanks be given to the members of the Nurses' Committee, and to Carrie M. Hall, Elizabeth Greener, Blanche Pfefferkorn, and the staff of the headquarters office of the National League of Nursing Education, for their devoted service to this cause.

2. Resolved: That the Committee on the Grading of Nursing Schools convey to the Members of the Board of Directors of the *American Journal of Nursing* and to its Editor, Mary M. Roberts, its deep appreciation of their policy in directing the great power of their magazine towards the whole-hearted support and thoughtful interpretation of the plans of the Grading Committee. It is believed that the rapid progress of the Committee's work during the past year has in large measure been made possible through this cooperation of the *American Journal of Nursing*.

3. Resolved: That a special vote of thanks be given to Janet M. Geister for her services in behalf of the Grading Committee; and that particular stress be laid upon her enthusiastic and tireless endeavor to interpret the plans of the Committee to the private duty nurse.

Nursing at the Top of the World

By Augusta Mueller, R.N.

FIVE years ago I wrote to a friend who had lived in Nome, Alaska, that I intended to go to Barrow as nurse in the Presbyterian Mission Hospital there. He wrote that even Nome people called Barrow the "Jumping-off Place," and that if I wanted to go 6,000 miles from home, to go in a different direction. Barrow is rather the end of the world; one has to walk only ten miles north to walk off the tip of the North American continent. All but two months of the year Barrow is cut off from the outside world, except for three mails that are brought up by dog team, in November, January and March. From the end of September until the end of October, there is absolutely no way of getting in or out of Barrow, and conditions are the same the latter part of May, all of June, and until the ice breaks up, in July usually, in the year I went to Barrow, the 22d of August. During the times mentioned, the Arctic Ocean is not safe for ships, nor frozen solidly enough for dog-team travel, and one cannot go by foot, for one has to pack all supplies, and igloos are about forty miles apart. When smallpox broke out in Barrow, two weeks after the last ship left, we didn't even try to get word "outside," because it would have taken at least twenty days to get to the nearest radio station, and longer than that for help to get to us from Nome. By that time the village would either be wiped out or every one would be well. Fortunately we had only about six cases, confined to three families.

Many years ago the white men entered that far-away place. During the whaling days of forty and more years ago, the whalers made Barrow their headquarters because, right off the shore, the valuable bowhead whale passed on his way north through the leads in the ice and came through again on his way south. With the coming of the whalers, traders and trappers, came the missionaries and school teachers. In 1920, after more than thirty-five years of medical missionary work among the northern natives, a long needed hospital was built by the Presbyterian Board of Home Missions. The hospital, the only one within a radius of 1,000 miles and the one nearest the North Pole, cares for the white folks and natives in that territory. Two white women, wives of Canadian Mounted Police officers, were brought to us from Herschel Island, way to the eastward of Barrow, to be operated on in the hospital, and a native woman was brought by dog team over 400 miles to have her leg amputated; a white woman, a teacher from Wainwright, also made a four-day dog-team trip to have her baby born in the hospital at Barrow. When I went to Barrow, in 1922, the hospital had been open a year and the natives were just getting over their fear of going away from their igloos to be cared for when ill. The last year that I was there, 1925–26, we treated over 3,000 dispensary cases and cared for thirty-eight hospital cases; ten babies were born in the hospital, fat, chubby little mites.

Eskimos are honest and trustworthy, shy until they become acquainted, when they are very talkative. They have a keen sense of humor, and some rather funny things happen in and out of the hospital. One day Tooka came to the hospital and wanted a white name for a baby. A number were given him; he picked one out and then began to talk about

village happenings, how many foxes were caught, what the prospects for a good season were, and the other usual Arctic topics of interest. Before he left we began to wonder why he wanted a baby's name and who had the baby. When we asked him, he said very quietly, "My wife, May, she have baby last night." He wasn't at all excited, maybe because it was his eighth child and it just meant one more mouth to feed and one more child for him to keep quiet in church. May always looked after the youngest in church, but it was always "up to" Tooka to keep the others in order. It was certainly amusing to watch the poor man trying to keep four or five little tots quiet. He always had such a relieved look on his face when one or more went to sleep. His new babies always came as a surprise to us hospital folk. The year before, May was staying in the hospital because her little boy had pneumonia and had been very ill. About 5 a. m. I heard a noise, went into the hall, and met our boy janitor all dressed to go outdoors. Questioning him, he said he was going for May's husband, that "she going to have baby soon." Truly it was soon; before I could get in to May or call anyone, the baby had arrived. She had delivered herself. When an Eskimo woman is alone during childbirth, as she often is, she kneels, sort of tilting on her heels, and when the baby is delivered she puts it in front of her and ties the cord, still keeping the kneeling posture until the placenta is delivered. When the women come to the hospital to have their babies, one never hears a sound until the baby cries, then the mother says, "Thank you," or the Eskimo equivalent, "Kyana."

One night we were at a meeting at the schoolhouse when a little girl came in and said that Eleak's wife was going to have a baby. The doctor sent some men from the meeting and told them to help take her to the hospital, but in a little while the child was back with the news that the baby was "borned," but things weren't going just right. The doctor had sent for his bag and we put on our ahtegas and, with an Eskimo as guide and interpreter, we started for the igloo. It was a nasty night to be out, no stars and black dark, the mercury about forty below zero, a fine night to lose one's way. The igloo was filled to overflowing with natives—men, women and children, and it was too cold a night to send them out. Eleak's wife was on the floor, her mother was on the sleeping shelf at the end of the room, holding a crying newborn baby girl. After much interpretation we found out that the placenta hadn't come when they sent the second time for the doctor, but that now all was fine. We didn't think the crowded igloo was the best place for a new mother, so we made arrangements to have her taken to the hospital. The doctor asked the grandmother what they had cut the cord with. She went to a corner and, from out a pile of old furs and other junk, hauled a huge pair of shears and showed us some sinew she had used to tie the cord with. A year before I would have gasped with horror, but I knew then, from experience, that the stump would not become infected and that the cord would drop off in three or four days, instead of the usual six or seven had it been tied under aseptic conditions in the hospital. I had on my double ahtega, a smocklike affair with a hood, made of fawn skin, a very warm outdoor garment, borrowed a belt from one of the native women and tucked the naked little mite up on my back, tied the belt around my waist and started for the hospital. That was the only time a newborn baby was admitted before its mother was.

During a bad influenza epidemic, a boy who had been more or less mentally deficient became violently insane. He was put in a small igloo and watched constantly; food and coal were supplied from the hospital. He could not be sent to Nome, because we didn't want any of our natives to leave the village while the epidemic was raging. All of us were sick, the doctor was the worst of all; he was in bed for two weeks. Willard, the insane boy, would not sleep without a narcotic, so every night at 9 o'clock I went to the igloo to administer a hypodermic of morphine. There certainly are more enjoyable things than going outdoors when one aches all over with the "flu" and when the wind is blowing a gale and the mercury is way below zero. Some nights it was so stormy that I had to take a native to guide me, because to one not used to traveling during the Arctic night in stormy weather it is a dangerous undertaking. I was lost, one time, within a dozen yards of the schoolhouse, and I never want to have that feeling again, of being lost in the cold dark Arctic region.

Old Kivalik, a partially paralyzed native, had a rather novel way of summoning a little boy who helped her by bringing in driftwood and doing odd jobs. All native igloos have ventilators in the roof, and when Kivalik wanted Isaac, she put a stick with a black rag attached up through the ventilator, and anyone who saw it looked for Isaac and sent him to her. Poor Isaac had no one to really care for him and was the dirtiest, most vermin-infested youngster in Barrow. One day in school the teacher noticed that he was quieter than usual, and investigated. The boy had been playing football two days before and had fractured his collar bone. He had not complained, but because he always had been very active the teacher became suspicious and sent him to the hospital. He needed cleaning up, as well as having the bone set. When he left the hospital he had acquired a sense of cleanliness and really did remarkably well, after that, in keeping himself neat and his head and body free from vermin.

The natives endure pain marvellously; even little children stand it very well. One little two-year-old, who was bitten through his lower lip by a dog, didn't shed a tear while the doctor cauterized it, and every day when his mother brought him for dressing he was more interested in the stick of candy on the stand than in what the doctor was doing to him.

The Stork's Horse

EPITAPHS for beloved animals have long been written, but apparently none was ever better deserved than that for Colonel Edgewood, a horse. He belonged to the Kentucky Committee for Mothers and Babies—a group of self-sacrificing nurses high up in the mountains of Leslie County. In the committee's current bulletin the flyleaf, bordered in black, has the following notice:

"In Memoriam: Colonel Edgewood, a horse, stricken suddenly in the line of duty; this devoted animal, high-spirited and eager, succumbed to an illness of unknown origin in August. He is the first horse we have lost. We had no better. We should like to put on record that he never had to be urged, even at the end of a long day's round, and that more than one mother and baby owe their safety to his speed and sure-footedness on dark winter nights. Ave atque vale!"

He had to be sure-footed to plant his flying hoofs safely on the ledges of Thousandsticks Mountain, above the village of Hyden, and to traverse the roads of hill counties on his errands of mercy and hope. No motors or carriages can transport the nurses along the precipitous paths. What the horse meant to the frontier in the early nineteenth century Colonel Edgewood and his kind mean to these remote lands, so close to great cities and modern civilization, but barred so effectively by their towering hills.—From an editorial in the *New York Times*.

A Peerless Source Book

The Use of the American Journal of Nursing in Schools of Nursing[1]

By Gail Fauerbach, R.N.

HOW may the *American Journal of Nursing* be made to function for a broader educational growth in our schools of nursing? Are its splendid inspirational material and scientific knowledge being incorporated in the daily life of our student nurse? Too often we see her as she waits in the library for her roommate, or in transit between classes, in an undirected fashion, finger the leaves, pausing a moment here and there as she is attracted by pictures. When the roommate appears, the *American Journal of Nursing* lies forgotten upon the shiny surface of the table. Not in this way will she learn the significance of the great grading program which occupies the center of the nursing stage, the lessons which Internationalism for nurses teaches, the wide field of the Red Cross, or the perplexing problems offered by the private duty question. Nor can she alone conduct her mental and spiritual development or stimulate her own interest in the *Journal*. This responsibility to vitalise the *Journal* and its rich material lies with the entire staff of the school of nursing.

To imbue our nurses with greater appreciation and to pave the way for a keener reception of its diverse contents, we must study it more understandingly ourselves and not be satisfied with a cursory reading of its crisp new pages at the time we remove the wrapper, or scan it with passive appreciation due to overpresent fatigue, and then, at the snapping of the light, relegate any thoughts it might have stirred to the realm of the unconscious! We must study and weigh the merit of these interchanges of opinions, the results of scientific experiments—agree or disagree, but, at all events—think!

Much is said in the curriculum of correlation of subjects with ward teaching! The *American Journal of Nursing* can be used as a potent factor in correlation with everything educational in our schools.

The instructor of nursing history is indeed fortunate in her opportunity to emphasise and broaden her course because of the wealth of articles relevant to history, past and contemporary. How simple and interesting to check and read in advance, to list under various heads the articles in the current numbers bearing upon nursing history, not to mention all those in old files! The weekly ten minute topic program which helps develop public speaking and better English expression may find enthusiastic response from these lists for collateral reading. Today it may be a digest of that article on "Modern Nursing in Brasil," next week, an account of the recent International Congress of Nurses in Geneva, Switzerland, or a description of St. Luke's International Hospital at Tokyo, or the recent organization of a History-of-Nursing-Society at Teachers College.

The less abstract appeals to the preliminary nurse in the form of personal hygiene, perhaps—she who is keeping a definite health chart and who watches her weight with a careful

[1] Read at a meeting of the Wisconsin League of Nursing Education, October, 1927.

eye. For her, there are posture charts, and innumerable suggestions to awaken her interest in health preservation. A recent article by Dr. Jesse Feiring Williams on "Smoking for Women" does not escape her in the June number, because she is familiar with his sane, scientific, and fair discussion of this mooted topic in her textbook. Bellevue's Conspicuous Service Award rivets her attention because of its heroic and dramatic appeal.

For the instructor of nursing procedures, there is suggestive material without end; the back files are replete with cuts and articles too numerous to mention. The dietitian and the instructor of psychology can meet on common ground through the medium of a paper on the "Psychology of Trays."

A supplementary list to enrich the course offered in medical and surgical nursing may be posted to correlate with the doctor's lectures as "Nursing in Pneumonia," or "Nursing in Nephritis." A small committee consisting of a head nurse, a supervisor, and an instructor should be responsible for these lists.

The course in Sanitation and Hygiene will be helped by a special bulletin now and then, as the field trips are planned. A notice to this effect, "To Detect Sewage Pollution" (*American Journal of Nursing*, August, 1927, p. 641), "The Detroit Filtration Plant" (*American Journal of Nursing*, October, 1925, p. 869) (compare with the Jones Island Plant, Milwaukee) will no doubt stimulate reading, especially if it is compulsory.

This sort of thing will require frequent conference with head nurses and instructors and will make for greater correlation. Anatomy, obstetrics, ethics, materia medica, chemistry, bacteriology, each subject furnishes its quota of well-written discussions to be listed for reference, mimeographed, and put into the hands of the students.

An added spur to the vigilance of the training school staff may be in the fact that the alert and very intelligent nurse will read reports and discussions which may make her wonder and even ask why such and such is not being done. We shall necessarily have to study more intensely dissertations on the new type of examination versus the old, as we may be questioned as to why we did not use the true and false type or the multiple completion tests in that last examination. In our teaching experience most of us have been conscious of the student who is an inspiration rather than a teaching problem.

With this program for more intensive use of the *American Journal of Nursing*, more than two school copies are necessary. We have heard too often that rather satisfied rejoinder, "We couldn't get the book!" There should be many accessible numbers, preferably one in every student's room. But how is this increase in circulation to take place when the *Journal* is $3 per annum? The purse of the student nurse, which is a "catch-all" for eye glasses, keys, fountain pens, and letters, rather than money, presents a vivid memory picture to most of us. At this point the objection may be heard that student subscription in the third year is sensible, but that the immaturity of the preliminary and second semester nurses should exclude them from individual obligation.

Personally, I feel that our beginners are at a stage in their education when enthusiasm is not lessened by fatigue and those causes which seem to reduce momentum in interest, and therefore present a greater degree of eagerness in the quest for knowledge.

Miss Nightingale in one of her inimitable admonitions said, "Don't talk about your plans; put them to work." It was to carry out the spirit of this idea that an *American Journal of Nursing* campaign was launched last week in the Milwaukee Central School of Nursing. Each group of students was approached and given what is known in the parlance of athletics as a "pep" talk on the appreciation of the *Journal*. Student committees were appointed, and the economic side of the question was disposed of in this way. If three dollars was too much for individual ownership, there was suggested a division of the financial burden between two roommates or three or four close friends. The latter plan reduced the expense to seventy-five cents a year, per student (the cost of a movie and a double chocolate malted milk, or the combined expense of five visits to the omnipresent candy shop) —in other words, less than one and one-half cents a week for the entire year per student.

The best results came from the first and second semester students, which in all fairness may be partially explained by the fact that the subscription agitator had less chance for contact with the older groups. All returns are not yet in, but thus far we have thirty pledges for new subscriptions. This campaign will continue. One hospital reports that all its third-year students are requested to become subscribers.

A most gratifying beginning has been made. We must go on in order to justify our stand and make our enthusiasm ring true. For are we not working together in the molding of a young woman who is developing in her profession, about whom Professor Kilpatrick says: "She is more than a means of health to her patient and to the success of her physician. She is that and distinctly so, else she performs no service. But she is more than that, she is a person of hopes and aspirations, with the lines of life stretching out before her; while she serves, she should also find expression and growth."

How You Catch Cold

THERE are two kinds of common colds—the cold which you catch from other people, and the cold you take even though no one around you has one. People who have adenoids or diseased tonsils or are run down, are likely to have either kind.

The germ which causes you to catch cold may enter your nose and throat passages from the air when the infected person talks, coughs, or sneezes. You may catch cold by using an unwashed glass, spoon or folk which has just been used by someone with a cold. The germs may be on your hands because you have touched something which has been handled by the person with a cold. Washing the hands before eating or before touching the face will help to prevent this.

People who take cold without "catching" it from other people are most often those who have poor circulation or some local infection in the nose or throat. Wearing either too little or too much clothing, so that the body is chilled or over-heated, often brings on a cold. If the skin is kept clean and healthy by a frequent warm bath, followed by a cold plunge or shower, or a dash of cold water, and a vigorous rubbing, the body can better stand quick changes of temperature.—From "Common Colds," Metropolitan Life Insurance Company, New York City.

The index and title page of Vol. XXVII, *American Journal of Nursing*, will be sent on request, as soon as it is ready.

Introducing Students to Communicable Disease Service

By Mary Elizabeth Pillsbury, R.N.

STUDENT nurses affiliating with the Yale School of Nursing at the New Haven Hospital come for a period varying from four months to eleven months and for various experiences, pediatric, surgery, and medicine separately or in combinations. The pediatric cycle of four months includes medical and surgical care of children, the care of the newborn and the care of the child with a communicable disease. The medical cycle, extending over a period of four months, includes an eight weeks' experience in the communicable disease department. The average length of time of the affiliating student in this service is six weeks. The students of the Yale School of Nursing have a three months' period in this department.

Students are assigned to the Isolation Pavilion in groups averaging four students each, and are introduced through a series of conferences, the instruction of the student nurse being planned with the idea of making her approach to this experience so gradual and reasonable as to reduce, almost to the zero point, the factor of menace to her own and the patients' health. To explain: the new student is on duty but four hours the first day, and six hours each the next two days, at all times during the least busy part of the day. She arrives on duty at 1 p. m. the first day, after having the morning off for rest. She is given the Manual of Instruction to read, in order to gain some familiarity with terms in daily use in this department. The supervisor then talks with her very informally—this hour being neither a class nor a lecture, but a means for laying the foundation of understanding for future experiences. This talk is called the initial conference. The past nursing experiences of the student are brought to light and their relationships with this department interpreted. The spirit of conscientious nursing is greatly stressed, with the need for making these isolated patients as happy as possible through attention to small details. The care of the whole patient is emphasized. The reasons for the student's initial hours are given her and the general principles of this department are explained, *i.e.*, the unit patient system, individual gown technic, plan of work, the use of the Procedure List, the teaching through the individual or group conference, etc.

The student is now ready to see demonstrated a treatment which is familiar to her and which she has merely to adapt to this branch of nursing—the taking of temperature, pulse and respiration. The supervisor introduces the student to her assistant, who demonstrates this treatment on the ward with the adult patients, explaining the hand scrub, the use of towels, the care of the watch and the manner in which the gowns are put on and removed. Immediately thereafter, and under direct supervision, the student puts this procedure into practice, taking several temperatures, with the pulse and respiration, until some degree of skill and assurance in this particular procedure is obtained.

All of this ward teaching is done on the adult service. Furthermore, all students, whether in the Pavilion for both pediatric and medical experience, or for pediatrics only, start with the

adult patients and have no contact with children for at least four to five days, and then only if they have adjusted themselves sufficiently as not to be a danger in the care of these more highly susceptible patients.

The student now meets the head nurse. She acquaints the student with the outstanding routines of the ward and then assigns her to some such experience as the afternoon care of a patient, the filling of ice caps or hot water bags, supplying the patient with fresh drinking water, carrying the diet tray to the patient, etc. In each of these procedures there is much of the old and a little of the new, so that the student feels a gradual sureness in all that she does. All this teaching is done through individual or group conference, as the need may be. The new student is cautioned to make no new move until she has asked the head nurse for advice and instruction. In this way a large amount of blind activity is prevented and the new student, feeling that she has constant help and guidance, finds herself a cheerful part of a large new branch of nursing service. At 4.30 p. m. the student reports off duty after a short conference with the supervisor, who reviews the afternoon's experiences and clears up any doubts in her mind.

The following day the student is on duty six hours. The time on duty may be from 7 to 9.30 a. m. and 3.30 to 7 p. m., or from 1 to 7 p. m. The object is to have the student on at the least busy part of the day. The patients assigned to her may number one or two, and are of the convalescent type. No treatments are given to her as yet. In the afternoon she meets a new experience, the care of the dishes and trays. The third day the student is on duty either morning or afternoon. During these last two days the head nurse arranges time to give the student a demonstration of a throat irrigation and of the set-up for blood culture, outlining the duties of the "clean" and the "contaminated" nurse.

The supervisor gives each student ten half-hour conferences during her stay in this service, these talks being on the procedures peculiar to this department. In addition, the students of the Yale School of Nursing have fifteen hours of the Principles and Practice of Communicable Disease Nursing, as well as their medical lectures.

Daily roll call at 7 a. m. affords opportunity for demonstration of any particular nursing treatment much used at that time, or for pointing out relationships of disease with community conditions, and for inquiring into the health of the student body. Much teaching is done in this five- to ten-minute assembly at the start of the day.

Each student is taught that every patient she has is a part of the community at large and affords means for spreading to others all that is taught him. Much can be done in this way in the teaching of health habits and in the prevention of disease.

This program of the introduction of new students into this special service and the follow-up instruction result in the student feeling much assurance during the early days of this experience through constant guidance. The health of the patient is preserved, in that cross-infection is reduced to the minimum. Nursing in communicable diseases is difficult and much depends upon the early teaching and constant supervision of the student from the moment she enters the department.

Recollections of Kaiserswerth

By Dessa M. Greek, R.N.

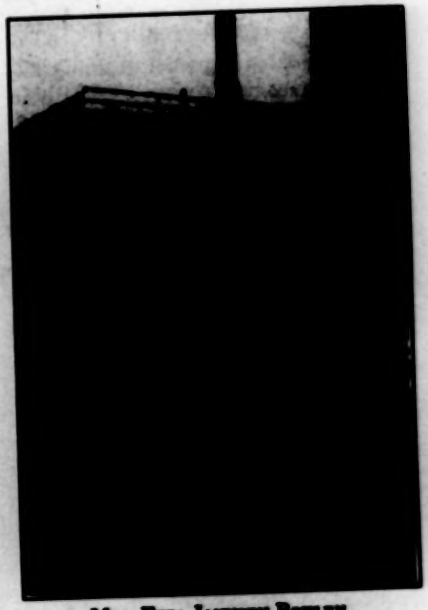
MRS. ETTA JANNSEN BOHLEN of Cicero, Ill., has intensely interested the nurses who cared for her during an illness by a review of her early training and expression of happiness in her service. Mrs. Bohlen was born in Rheiderland, Germany, in 1850, and was confirmed in the Lutheran Church at Lammerts, Fehn. She was urged by her minister to train for a nurse, and after the death of her mother she went to Emden to enter training.

In 1873 she was sent to Kaiserswerth on the Rhine. One year later, she was forced to return to Emden, on account of a typhoid epidemic in which many patients were lost. She remained there until she came to America to wed Rev. Mr. Bohlen, a graduate of Concordia Seminary, St. Louis, Mo., whom she had met while at Lammerts.

Mrs. Bohlen's recollections of Kaiserswerth are most interesting. The hospital was started in 1850 by Rev. P. F. Fliedner and two "Sisters." He was in charge of the Training School at the time Florence Nightingale had her training there and after his death, in 1865, his wife and son continued his work. Under them Mrs. Bohlen received her training.

During a three years' course, the nurses or "Sisters," as they were called, had room, board and laundry and received thirty dollars a year for their services. Two uniforms of dotted blue material like our calico were furnished to wear during the week, but on Sunday the nurses wore black. Their sheer white caps were made like hoods and tied with a large bow under the chin.

Mrs. Bohlen cared for sick women and children and the insane. She carried water and trays from the basement to the third story. Hot dressings were prepared over an alcohol lamp in the patient's room. Visiting Sisters were sent out from the hospital, which received remuneration for their services.



Mrs. Etta Jannsen Bohlen

The graduate nurses of Kaiserswerth are received everywhere, and when too old for service they return to the institution to be cared for the remainder of their lives. At present there are two buildings for such nurses, and a third is in construction. These are called "Feirrabendhausen."

The hospital is now a part of a large group of buildings situated in a beautiful park on the Rhine and cares for all kinds of disease. Many war orphans are cared for, and many of the patients pay nothing. The institution

has a large estate partly under cultivation and receives donations from friends. Many destitute patients remain and do the agricultural work.

Mrs. Bohlen says her training has been of great help to her, especially in the rearing of her family. Her wonderful personality, and happiness in meeting people, must have made a lasting place for her in her school. She receives letters from classmates, who have served humanity well, and have gone back to Kaiserswerth to finish their lives among their very early associations.

A Family Interlude

By Maude E. Truesdale, R.N.

"QUIET, stolid, unemotional," so the visiting nurse would have described Edward. She was new in the work then; not so long afterward she learned the foolishness of drawing too many conclusions during the first visit. The woman, too, seemed a colorless sort, of Polish descent, and decidedly cold in comparison with the Italian patients she was accustomed to visiting. First impressions, however, while strong, are not always to be trusted.

It had been such a surprise that first day, when she opened the door into their rooms. All the way up the stairs—the darkest, steepest and "spookiest" she had yet climbed—in an old tenement under the shadow of the Bridge, she had been picturing with sinking heart the conditions she would be apt to find. Probably dirt unspeakable! Then to open the door into this clean, bright kitchen, poor and bare, of course, but spotless!

There was a new baby to be bathed. His clothes had been arranged in an orderly pile, and the water was heating. The other children crowded around the nurse with interest, their hands and faces clean and literally shining from the scrubbing the father had given them. Quietly he brought whatever the nurse required, and soon mother and baby were comfortably settled for the day. So it was every day. Always the clean clothing and hot water were ready; the children well cared for; everything neat and in order; Mary, the mother, placid and cheerful. Certainly a happy little family in spite of such poor surroundings.

But the baby wasn't doing so well, it was necessary to give him a formula, and the nurse was watching his weight rather closely. Hurrying down the alley toward the tenement one morning, a few weeks later, she met one of the neighbors, who asked if she were on her way to Mary's, adding with great excitement before the nurse could reply: "Oh, don't go there! You might get *killed*; her man shot up everything last night!" "Oh, nonsense, nobody ever hurts a nurse. I'll go and see what's left," she returned with a calmness she was far from feeling. "Besides, he is probably in jail," which proved to be true.

Mary opened the door, her face swollen from crying; both eyes were blackened. Sobbing hysterically at sight of the nurse, she immediately began telling her troubles, which had all started over her smashing the still in a moment of temper. (The *still*—now where had that been all this

time?) Blows at once had followed, as evidenced today by the discolored eyes, and then Edward had left the house, returning in the evening with a revolver and proceeding to "shoot up" the place. One bullet, aimed at Mary as she fled to the roof, had passed through the partition about twelve inches above the head of their lodger, as he lay in his bed. "He packed up and left right away," complained Mary in rather a plaintive, puzzled tone. "I'm not surprised," fervently murmured the nurse.

Presently Mary went into her bedroom, returning with a photograph and some cheap silk stockings, which she held caressingly against her face. Their wedding picture, she explained between sobs, pressing it into the nurse's hands. "He never acted like this before; he always brought me things," and tears were spotting the silk stockings, the last present he had brought home. "Oh, the faithfulness of women—the poor fools!" thought the nurse with mingled feelings of exasperation and sympathy. Well she knew there would be little evidence presented against Edward in court by Mary! And she had thought her cold!

Going in to weigh the baby a few days later, a happy domestic scene met her surprised eyes. Edward (out on bail), quiet, stolid, unemotional, was rocking contentedly as he held the baby carefully in his arms and gave him his bottle, the tiny hand firmly gripped around his thumb. The other children hovered happily on each side. Mary beamed in the background, the brightness of her smile a trifle overcast by the shadows around her eyes—shadows fading now to a delicate lavender tint. Involuntarily the nurse's lips parted in the exclamation: "Edward, what *made* you do it?" Not a flicker of embarrassment disturbed the calm serenity of his countenance as, shifting his small son into a more comfortable position, he replied: "I dunno; must have gone crazy."

And the baby had gained eight ounces.

Community Health Centers

THE latest addition to health centers in Maryland was recently fitted up and opened at Kitzmiller in Garrett County, according to a report from the State Department of Health. In every sense of the word it is a community affair, of the community, by it, and for it. The local Health Club, under the leadership of the public health nurse of that section of the county started the ball rolling. A small frame building centrally located was secured and everybody got busy.

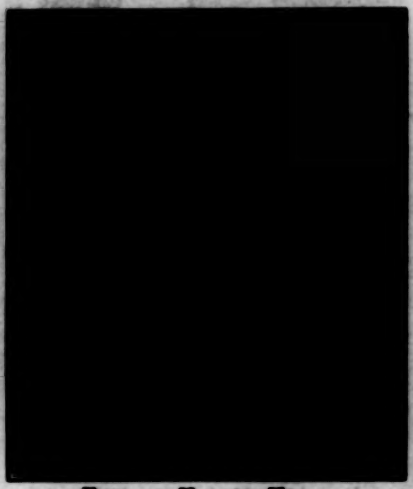
Some of the industrial concerns provided the wherewithal for lumber, paint and other supplies. The money was deposited in the local bank to be drawn upon as needed. Three of the best painters gave their time and transformed the exterior of the little building into a place of white and green beauty. Three more craftsmen skilled in the use of hammer and saw worked after hours on the interior, putting up partitions, dividing the space into two rooms and building shelves that are the joy of the nurse's heart because they hold her outfit of sheets, pillowcases and other supplies for her classes, for the health conferences and clinics, and for her loan closet for emergency needs.

Electric lights were installed by two other neighbors and then the teacher of home economics in the Kitzmiller High School and the girls in her classes had their turn at beautifying the interior. The girls tinted the ceiling a light buff and the walls a darker shade and selected dainty curtains to blend with the color scheme and finally, the furniture for the waiting room was donated by a business firm in an adjoining town.

This new center serves, as do those that are at other places scattered throughout the state, as the headquarters of the local public health nurse. It also affords a convenient place for community meetings, for health conferences, diphtheria immunization clinics, as well as for health clubs and classes, and for other health activities.

Two Recent Residences

Hampton House, Johns Hopkins Hospital, and the Residence of the Nurses of the Nebraska Methodist Episcopal Hospital



Entrance Hampton House

I

HAMPTON HOUSE, erected as a part of the expansion program now in progress at the Johns Hopkins Hospital, is the residence of twenty-eight graduate nurses and of the older students in the school of nursing. As an entire hospital floor, containing a model ward, private room, classrooms, and amphitheatre, offices and study rooms, is devoted to teaching, no space in Hampton House is allotted to educational purposes and the building has a homelike atmosphere throughout. The beauty and dignity of the entrance is apparent in the illustration. The spacious drawing room, or the "large sitting room," as it is familiarly known, is a beautifully proportioned room in which the well known portrait of Isabel Hampton Robb is the center of attraction.

A Student's Room, Hampton House

Classroom, Nebraska Methodist Hospital

Nile green walls, silver sconces, soft-toned rugs and furniture, the grand piano on which Miss Lawler has decreed that only *good* music shall be played, appropriate bits of glass and pottery and the thoughtful arrangement for many groupings of occupants combine to make a room of rare charm. Nurses' rooms likewise are comfortable, simple and homelike. The swimming pool awaits a gift from some generous donor to complete it. The roof, extending over the entire

building, has large sun parlors and spacious porches. With its gay hangings, an upright piano "for jazz," splendid vistas of city and harbor, and its complete isolation from all the cares of the day, the roof is a constant source of joy.

II

"We have been working for a residence for our nurses for ten years,"

The Roof, Hampton House

The Large Sitting Room, Hampton House

Blanche M. Fuller, Superintendent of Nebraska Methodist Hospital, tells us, and adds "we are finding it very satisfactory." The lounge and reception room, which is fifty feet by thirty-two feet, is well proportioned and handsomely furnished, as the picture shows. The Steinway piano is not only the point of interest in the picture, but often the center of attraction when the room is being used. Its use warrants all the thought and effort that have gone into it and it is especially popular over the week-ends when the students are receiving their friends.

Sleeping rooms are planned to accommodate two students but are spacious and are well equipped for each individual. Shower baths and toilets are provided in the ratio of one to five.

Supt. of Nurses' Parlor, Nebraska Methodist Hospital

Lounge and Reception Room, Nebraska Methodist Hospital

The ground floor of one wing is devoted to a well lighted, well ventilated teaching unit. A reading-room is on the first floor. Suitable and nicely appointed suites are provided for the staff, including the director of the school and the house mother.

Aims for 1928

"WHAT shall be our major professional aim in 1928?" The question was put to representative nurses throughout the country. "Shall it be education, service, distribution of service, care of the patient of moderate means? Shall it be an effort to obtain community understanding? For what shall we aim," wrote the editor. Back came the replies, from which we excerpt the following paragraphs. The task they set is gigantic. It cannot be accomplished in one year or in many years. It will never be accomplished if nurses themselves do not face the issue with courage, with knowledge, with open minds and generous hearts. But who is there to say that a profession that has grown, in little more than fifty years, from an idea to marshalled ranks of thousands upon thousands of trained women, lacks courage?

What the Presidents Wrote

"The Grading Committee will be active throughout the year. It will be concentrating on the patient of modest means, on the problem of the distribution of nurses, and on the work that has already been started in hourly and group nursing. Will not, therefore, the emphasis on education be made, and will not all of these points spell service? Therefore, if we stress the *great task of obtaining understanding and cooperation*, we shall be indirectly stressing all the other points.

"I hope that by the time the work of the Grading Committee is finished, hourly nursing and group nursing will be established facts in our communities, and this, I believe, will go a long way toward eliminating many of the problems that now confront us."

S. Lillian Clayton,
President A. N. A.

"I firmly believe that the poor distribution of nursing service is at the bottom of a great deal of the criticism of shortage of nurses, et cetera, but as to how much that distribution can be controlled and directed to bring about a more even distribution, I have no new ideas.

"If the solution is through hourly and group nursing, I would certainly be in favor of a great deal of experimentation with it and the accompanying problem of the registries.

"Is the 'task' of obtaining community understanding and through it community cooperation the most important matter on the immediate horizon? I would say that I think Miss Gladwin's paper in San Francisco pointed out the need for that in no uncertain tone."

Carrie M. Hall,
President N. L. N. E.

"Community understanding of nursing and a full hearted cooperation of the employers of nurses together with the medical profession, will only come as nurses exemplify by their lives that: first, education and service are blended together as a great professional contribution to the community, and second, that nurses are willing to consider the needs of the community even to the extent of overthrowing old traditions and trying out entirely new plans.

"It is my firm belief that properly conducted official registries for nurses can do more toward a proper distribution of nursing service and an understanding of the nursing profession by the community, than anything else that could be organized. I therefore feel it very important that organization of registries be given very careful consideration by all nursing organizations and by the *American Journal of Nursing*. Much depends upon the type of organization of the registry. On the board of directors there must be representation of both the medical profession and the laity. To have the medical group and lay persons merely in an advisory capacity does not meet with success. It is also necessary for the Registry to register all types of nurses, including the practical, if real success is to be achieved."

Anne L. Hanson,
President N. O. P. H. N.

Miss Goodrich's View

"For some time the important first concern of the profession has in my mind fallen under two heads, the *centralization of the nursing activities in any given community*, and the *centralization of nursing education over as extensive an area as is possible*. I would commend as a textbook on the importance of community understanding and cooperation, Dr. John Dewey's last book, 'The Public and Its Problems.' It reiterates what Chief Justice Brandeis asserted some time ago; namely, the importance of a decentralization which will provide a centralization of community effort

within limited geographical areas. This would seem perhaps to contradict the statement in relation to the centralization of nursing education. I think it does not.

"The machinery of education is a costly affair. The scientific knowledge required for nursing finds its most comprehensive and intensive expression in the university. Theoretical content should be obtained, therefore, if possible through this means, and where not possible there should be a coming together of a number of schools in order to provide this costly scientific content.

"We are too profoundly and soundly aware of the importance of the application of knowledge to the practical field to allow any separation. It is, therefore, imperative and from the standpoint of the community program we have in mind an excellent thing, that the theory can be applied with such economic and social value to any given community."

ANNIE W. GOODRICH,
(Yale School of Nursing).

COMMUNITY UNDERSTANDING

"I think the question of *community understanding* is extraordinarily important just now with the grading study going on as a background, and I am inclined to think that is one of the most important points for emphasis during the coming year. I think the community is learning to understand the public health group from frequent intercourse with it under normal conditions. Private duty nursing is usually interpreted to the public through a single individual who may or may not be really representative of her profession, and who in most cases has little opportunity to deal with more than individuals herself. I am inclined to think, therefore, that of the three proposed points of emphasis you suggest, the last, the task of obtaining community understanding, and through it community coöperation for the nursing profession, is perhaps the most important question for the coming year."

MARY S. GARDNER, Rhode Island.

"I think we have been going at it at the wrong end, and treating the symptoms rather than the disease. I think the trouble lies in our lack of a good system of caring for any given community. The task of *obtaining community understanding* is a very important one. It rests so largely upon the way nurses will present nursing to a community, also what the community wants of nurses. As things stand now, I believe that this last question in your letter is really the most important, and involves possibly all of the former. When we consider the inadequacy of our registries, the lack of knowledge of organization on the part of the nurses, the poor understanding of what good service is and how all of this appears in the minds of the people I believe it is here we should place our emphasis. After all we are here to serve and serve the people in the very best way possible, and we should know how to do this, and our nurses should be educated to that idea."

ANNA C. JAMMÉ, California.

"Education really is our salvation—educating ourselves and the people whom we serve. This program will carry on into the years and perhaps will be directed largely by the findings of the Grading Committee. It seems to me that the immediate job which does not need to wait for the findings of the Grading Committee is to provide nursing service *which actually covers the need for service*. The Public Health Nurses have been and are still doing the pioneer job of creating community interest in nursing service and the desire of the community to coöperate."

GRACE PHELPS, Oregon.

ECONOMY IN DISTRIBUTION OF NURSES

"I think if I were to put into words the two important things in the work of the A. N. A. for the following year, I should say that the *community understanding* was one of the outstanding if not the outstanding subject but I think this can best be obtained by studying the whole problem of the distribution of nurses. I do not believe the experiments in hourly and group nursing are nearly as important, important as they are, as trying to get some system of registries where nurses can be sent to parts of the country where they are needed. I believe in a system of registries in direct touch with each other and having a method by which nurses could be sent where and as they are needed and with an agreement as to prices, that the nurses going into a community should accept the prices charged by the nurses in that community; also, the nurse going from a community where the prices are not high to one that is higher should receive the same compensation. In this state, this year, we are going to put our emphasis on improving the care of the patient in the hospital thereby making for a more sound training for the nurse. What I consider the weakest thing in nursing today is the actual care of the patient."

ADDA ELDRIDGE, Wisconsin.

"The task of obtaining community understanding and, through it, community coöperation, is, indeed, a challenge for us nurses and as

a profession we are still not understood. For the most part, the community does not consider nursing an essential service for which it has a responsibility. To my mind, one of the greatest needs today is the more economical use of the nursing service available; for experimentation with group nursing, hourly nursing, and perhaps other types of organization which have not yet been thought of."

ABBIE ROBERTS, Tennessee.

"The suggestion that we concentrate on the patient of modest means and the distribution of nurses with its ramifications into the registries and with experiments in hourly and group nursing, impresses me as being the more important in this particular section of the country. Second to that, the idea of service, in fact to me the two are closely allied, injecting perhaps in the service idea some of the ideas of modern business, not the old type of self-sacrificing service, but a better service or a fair exchange to the patient without the long hours and less pay. It needs also a study of the possibilities of new fields in nursing service. The care of the psychiatric patient in our particular state is left entirely to the attendant group and the greater part of the rural nursing is done by the practical nurse or untrained individual."

IRMA LAW, Missouri.

"We believe some emphasis should be put on the problem of the patient of moderate means, as it is from a part of that group that nurses receive the most criticism, and also the most opposition to the better educated nurse. There is no doubt that *better community understanding and coöperation are very much needed*, and in our own state the problem of the distribution of nurses is a very serious one. The larger towns are oversupplied with nurses, while the smaller towns and rural communities are without nursing service."

ADAH L. HERSHEY, Iowa.

IMPORTANCE OF EDUCATION

"The two things that I would like to see stressed in the following year are education toward better standards in nursing and the obtaining of better coöperation with the community. In my opinion these are the two outstanding needs in this section of the country. We do not have state-wide inspection in our schools and as a result there is bound to be a wide variety in the types of schools and the manner in which the basic requirements are given to students. The salvation seems to be more appreciation of standards on the part of those who control the situation. It would also be a wonderful help if the ones in charge of educational work had more opportunity to avail themselves of the many good things which they might get through their *institutions of higher education*."

ELIZABETH S. SOULE, Washington.

MORE CAREFUL SELECTION OF STUDENTS

"When I speak of education I do not mean sufficient credits to meet given standards academically, but education as President Mason of Chicago or President Frank of Wisconsin are presenting it today. After all, to become educated the process must be such as will enable the individual to express the finer, nobler qualities of one's character through the vocation or profession one has chosen. 'The work that pays is the work of the skilled hands directed by the cool head and inspired by the loving heart.' May we seek the young woman who sincerely desires to possess the greater number of womanly characteristics, give her the theoretical technic of nursing that has been proven practically valuable and most of our worries and questionings of today will disappear. This reduces my views for 1928 aims to about two points; namely, a selective student body—selective from vocational standpoint and the individual wholly equipped to express her finer characteristics in her vocation."

V. LOTA LORIMER, Ohio.

"Emphasis would not need to be placed on 'service' if those serving really wanted to serve. As long as, academically, nursing does not measure up to those vocations young women with culture and education prefer to choose, we will continue to draw largely not only those who lack culture and education but those who, because of such lack, dislike serving. I doubt whether any kind of emphasis can cure an attitude so fundamentally wrong. This condition can be changed only through a community made intelligent in the matter. To expect real reform through efforts of any group that now grudgingly permits nurse education to me seems illogical. Not until the rest of the community, *and women in the community especially, sense the injustice of the system, can nursing* hope to shake off the parasitic impediments that still prey upon it, by taking its place in the educational system alongside its at-present rivals."

GRACE ROSS, Michigan.

PUBLIC SUPPORT OF SCHOOLS

"After four years of educational work among nurses, the laity, and hospital people, I think if we did nothing more this coming year than to concentrate on the problem of

caring for patients of moderate means, it would be well. *'Obtaining community understanding and through it, community coöperation* is the most important matter on the immediate horizon.' Our hospitals are bearing absolutely all the expense they can now in regard to training nurses, and unless we can get the public to recognise that the schools of nursing should be financed the same as other schools and colleges, through public funds obtained through legislation, we will not get the coöperation of the community because the patients who make up the community, will still pay the bills."

A. L. Dietrich, Texas.

"The need of community understanding and through it community coöperation is one of the most important matters confronting the nursing organisations of Alabama. We should like to impress the public with the fact that the education of the nurse is a matter of great public concern and that provision should be made in the public school system and in the State Universities for courses suitable to the needs of the nursing profession."

Annie M. Beddow, Alabama.

"It is important that we make a new and widespread effort to obtain understanding of our needs and of our aims by the people at large. The fact that nursing students have done such an enormous amount of work for so many years and have been assumed to acquire their education while doing it, makes it exceedingly difficult for the public, hospital boards, and training school committees to become accustomed to the expenditure of funds for the education of the nurse, or to understand that she needs recreational facilities and social opportunities as does any other type of student. It means that we are running around in a circle. We cannot have better schools until we have economic independence. We cannot have economic independence until we have an enlightened public."

Ethel P. Clarke, Indiana.

Nurses Must Understand Each Other

"The promotion of greater understanding amongst the various groups of nurses I believe to be one of the most important concerns of the profession for the present. Until this understanding is established, it will be difficult to convince the private duty nurses that the efforts of those other groups are put forth, not only to serve the public more efficiently, but to obtain more normal living conditions for all nurses, and more regular employment as well. Nor will those of the other groups see that the opposition they are encountering, in most cases, arises from a real interest in bedside nursing rather than in selfishness or a fear of being dominated by those outside their immediate circle. With confidence in one another secured, our next task should be to gain understanding from the medical profession and from the public. A difficult task, I will admit, but it can be done. By taking the people into our confidence we can convince them of our sincerity in the desire to serve all classes by giving the best kind of nursing to all. Since the middle class seems to be the most seriously affected by our present arrangement, we should concentrate upon providing for them."

Loretta Mulherin, Colorado.

Hospital's Obligation to Patient

I should like to see some attention given to the question of how much nursing service should a private patient expect from the hospital. There is another side to the question beside that of the patient. The student nurses in the old days received in the private wards considerable experience in the care of private patients, and were, therefore, much better prepared for private duty nursing than they are at the present time. The students, are, therefore, losing a very valuable preparation for a field which claims a larger number of nurses than any other. I should like very much to see some thought and attention given to this particular question. A nurse who had been out of this country for three years, with an important school of nursing in a European country recently returned in order to brush up on nursing questions. During her stay here she had an opportunity to review a good many phases of work, both in the institutional and in the public health field. In summarising her thoughts in the matter, she said that she felt that a very decided change had come about during her absence, either in the conditions in this country, or in her own point of view. She felt that we were emphasising nurses, rather than nursing. She received the impression that too much emphasis was being placed upon the possession of a degree; that given two women, one with a good education, a good background of experience and personal qualifications, and another with a college degree without very much experience, preference would be given to the second in a choice for a given position. I am wondering if there is not some truth in this? Perhaps in our effort to secure a better preliminary educational background the pendulum has swung just a little too far in that direction.

Clara D. Noyes, American Red Cross.

Our Contributors

Thomas Klein, M.D., and Elizabeth Derrell, R.N., are accustomed to working together in the care of arthritis patients in the medical wards of the Presbyterian Hospital, Philadelphia, where Miss Derrell is Supervisor.

Florance R. Unwin, R.N., is assistant to the director of nurses at the 7000-bed Manhattan State Hospital, New York City.

We asked Miss Noyes to write the fascinating story of the Constantinople school because Miss Nelson's account was much too modest.

Margaret Bussche, B.S., R.N., is a member of the faculty of the Stanford School of Nursing, San Francisco, and a graduate of the University of Cincinnati School of Nursing.

Margaret C. Foley, R.N., a graduate of the School of Nursing of Mercy Hospital, Oshkosh, Wisconsin, has for about five years assisted one of the physicians at the Oshkosh Clinic.

We regret that we could not use both the maps mentioned in the article by Lena Dixon Walker, R.N., Instructor in the Aultman School of Nursing, Canton, Ohio. The originals were displayed at the Ohio State meeting in Dayton, last spring.

V. L. Ellicott, M.D., Dr. P.H., is epidemiologist for the City Health Department, Baltimore, Maryland.

Carrie Hunt McCann, R.N., is a graduate of the School at Mt. Sinai Hospital, Cleveland. For three years she has been on the breast-expression staff of the Babies' and Children's Dispensary, and she is accustomed to answering calls from many sources such as midwife cases registered at City Hall, Infant Hygiene Classes, the Maternity Hospital Dispensary, and from private physicians.

"Nursing at the Top of the World" was written by Augusta Mueller, R.N., a graduate of the Metropolitan School of Nursing, New York City.

The article on the use of the *Journal* was written without the knowledge of the editors and therefore represents actual experience. Gail Fauerbach, A.B., R.N., the author, is an instructor at the Central School of Nursing, Milwaukee, Wisconsin.

Mary Elizabeth Pillsbury, B.S., R.N., resigned the position of Supervisor of the Isolation Department in the Yale School of Nursing, which she had held for three years, to continue her studies at Teachers College. She is completing the manuscript for a book on the nursing of communicable diseases.

The great enjoyment of the nurses at Presbyterian Hospital, Chicago, where she is a Supervisor, prompted Deana M. Grook, R.N., to write some of Mrs. Bohlen's reminiscences for the *Journal*.

Visiting nurses do see life! Maude E. Truesdale, R.N., who is a graduate of Waterbury Hospital, sees it from the vantage point of a Supervisor on the staff of the Visiting Nurses' Association of Brooklyn.

Rev. C. B. Moulinier, S.J., President of the Catholic Hospital Association, for years has plead most eloquently for the standardization of hospitals. It is encouraging that he is now using his remarkable gifts of idealism and persuasive oratory in the interest of sound education for nurses.

Shirley Titus, B.S., R.N., made a witty defense of reasonable academic standards for nurses at the meeting of the American College of Surgeons, but it is extraordinary that the point required defense before that highly educated body.

No person is better qualified to speak on "State Standards" than Adda Eldredge, R.N., ex-Interstate Secretary of the American Nurses' Association and Director of Nursing Education for Wisconsin.

Editorials

Around the world into hospitals and homes, down city streets and through country lanes, the editors send warmest wishes for happiness in the New Year to all nurses.

Professional Aims for 1928

THE greatest need of the nursing profession today is understanding. So wrote the majority of the correspondents who contributed the ideas expressed on page 50. The opinions were not lightly expressed. They came from some of the most thoughtful women in the profession. The importance of securing community understanding as a basis for coöperation in developing our professoinal service can hardly be overestimated. But our correspondents overlooked something which is even greater. We must first secure the understanding and coöperation of each other! Nurses in each of the three groups must believe in the honesty of purpose, even when they are in painful disagreement with the immediate aims, of each of the other groups.

Nursing needs community understanding of the fundamental unsoundness of an educational system that has no firm economic basis. Nursing needs community understanding of the economic unsoundness of our present system of private duty which makes it obligatory for nurses to endure enforced periods of unemployment. Nursing needs community understanding of the selfless idealism that flames in every true nurse though it may be apparent only in times of strain, such as the disasters of the last year that made such demands on enrolled Red Cross nurses. Nursing needs a well organised campaign of public information. This we may hope for under the guidance of the National Organization for Public Health Nursing and the American Nurses' Association.

The part of the individual nurse is clear. Each nurse must take upon herself the obligation of finding out more than she now knows of the work and the conditions of work of each of the other groups. Private duty nurses need more knowledge than they have of the problems of the administrators and the public health nurses. Each of the others needs to know much more about private duty. When we know these things, the profession will be in a position to plan nursing services which will really nurse whole communities and communities will support services which demonstrate their ability to function efficiently.

The New Year opens on a none too happy profession. It is an adolescent profession full of yearnings, possessed of extraordinary social power which it has not yet learned to use, and like the adolescent, somewhat awkward in some of its gestures. Like other adolescents, nursing will grow up. It is in that painful process now. It will grow in beauty of service if each nurse assumes real responsibility for knowing her own profession, in order that she may interpret it correctly to those upon whom it is dependent for a stable economic foundation.

The "Journal" in 1928

YOUR magazine begins the year in an optimistic and healthy condition. The change of printers and engravers has been consummated with comparatively little difficulty. The service each company gives is of the highest order, with the result that we have a really handsome magazine which is a fitting expression to the world of the solid worth of the

profession it represents. The professional and literary content of the magazine is of an increasingly high order. Never have we had finer coöperation from the profession itself nor from the allied field of medicine in securing articles designed to meet the expressed needs of nurses. The promises already made for material for publication in 1928 give reason to suppose that this happy condition will continue. Those who write for us are not merely gratifying a persistent editor, they are writing for a whole profession. They write painstakingly. They write with enthusiasm. They write with authority. State Associations and State Leagues are wonderfully coöperative in sending us papers from their meetings and these, coming from the very heart of the profession itself, are the foundations of our thinking.

Many unsolicited manuscripts are offered the *Journal*. This, too, is a sign of health. Some of these have fitted perfectly into the current plan of the magazine and have been promptly accepted. Some have had to be rejected, often because they somewhat duplicated material in hand or in the making, or for other reasons. All of them have been treasure trove to the editor for they are an index to the stream of thought within the profession. The editors are grateful to every person who has sent a manuscript, a suggestion, a question, or even a criticism.

The *Journal* health is financial as well as professional, and the American Nurses' Association, to which it belongs, permits profits to be applied on the improvement of the magazine itself. The editors therefore are happy to announce the two new services which begin with this issue. All official registries are hereafter to be enumerated monthly in the advertising pages, like those of the Official Directory. This is a service to the private duty nurses which it is hoped is but the beginning of a unified system of "distributing centres" which will make possible a vastly improved service to both patients and nurses.

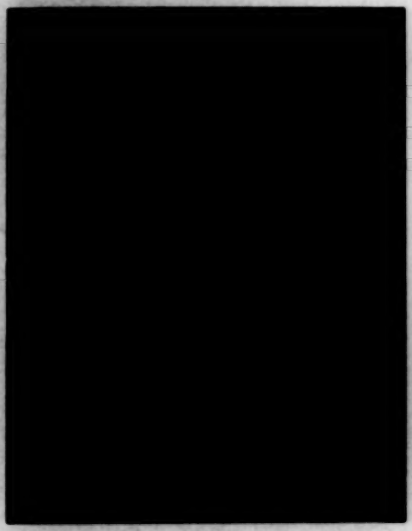
The other addition is that of a page on general literature to be conducted by Isabel Ely Lord. Miss Lord has been librarian at Bryn Mawr and a member of the faculty at Pratt Institute. She is an experienced reviewer. Her first page is experimental. Our readers are urged to send suggestions or questions on the type of information on current literature that would be most useful. This promises to be at one and the same time a stimulating and a time-saving service. All nurses love to drop into the "pools of thought" that take them out of themselves. None have time to waste in sampling books. Miss Lord's service should save busy nurse readers some disappointments and open many a new door.

The *Journal* in 1928 will be "bigger and better" than ever before. This is because the editors, who are your agents, are receiving marvellous support from a profession which is bigger and, despite some of its difficulties and growing pains, better than ever.

Who's Who in the Nursing World

THE gleam of the Nightingale torch lit the taper of service of the rural Wisconsin schoolteacher, Jane Van De Vrede, and led her through the Milwaukee County Hospital School of Nursing, and into the nursing field.

Postgraduate and private courses opened the technical door of opportunity to laboratory work, which took her to Savannah, Georgia, since which time she has been identified with the South and Southern nurses. As private duty nurse, as industrial nurse, as



LXXVIII. JANE VAN DE VREDE, R.N.

special instructor to student nurses, Miss Van De Vrede was an industrious member of her profession, finding time for volunteer service in organization work of the local and state nursing groups and the American Red Cross.

The War program claimed her services as Division Director of Nursing for the Southern states, and enlarged her opportunities for service, one of which was the establishment of the course in public health nursing at Peabody College. The sobriquet, Jane Southern, at first distinguishing her territorially, has become an affectionate and honored title which she has merited by the stalwart support she has given to the advancement of Southern nursing and nurses. She has held many positions of honor and trust in nursing and allied fields, including those of Vice President of the National Organization for Public Health Nursing and of the American Nurses' Association.

She is at present Executive Secretary of the Georgia State Nurses' Association and Secretary of the Board of Examiners of Nurses for Georgia, to which she has been appointed by five Georgia governors consecutively. She has been zealous in civic, social and business organizations, having served on boards of trustees or directors of the Woman's Division of the Chamber of Commerce and the Business and Professional Women's Clubs, the Georgia Children's Home Society, the Georgia Tuberculosis Association, the Atlanta School of Social Work (a school for the training of negro social workers), believing they are all closely allied to the highest development of nursing as an essential community service.

Miss Van De Vrede is the author of a number of articles relating to nursing which have been published in leading medical and nursing journals. She edits two nursing pages in the monthly *Journal of the Medical Association of Georgia*.

A deeply religious nature which she attributes to the Dutch Reformed faith of her ancestors, finds expression in membership in the Presbyterian Church and in social service.

To her energetic nature a hobby is indispensable, and she has had various nicknames. Her favorites are: "Jenny Wren," "Jane Southern," and more recently, "The Philosopher." She has attained fair skill as an amateur carpenter, but she excels in the domestic arts. Naturally a good "Dutch" cook, she found "new worlds to conquer" in the hot biscuits, barbecue and Virginia spoon bread of Southern fame. She makes jellies and jams, and cans the winter supply of corn and okra. One day she may market them as "The Jane Peace Products" (Vrede is the Dutch word for peace) and advertise them in the *American Journal of Nursing!*

Ethical Problems

The Editor and the Committee on Ethical Standards will be glad to consider other solutions than those offered each month to the ethical problems submitted for discussion. They will welcome additional problems.

Problem I

WHAT is the distinction between practising medicine and practising nursing?

A nurse was called on a case. She phoned the doctor for a diagnosis and for orders and was told the patient had diabetes. Orders were "to put the patient on a diabetic diet" but no specific orders regarding the quality or quantity of food were given. The nurse asked the doctor to outline the diet in greater detail, as she had no means of knowing what the patient's medical needs were. The doctor became irritated and told her "to go ahead and use common-sense." The nurse, not wishing to offend him, proceeded to follow this advice. The patient did not suffer through her ministrations but neither did she believe that he was aided to any great degree. Did this nurse practice medicine?

Answer: She did. An extenuating circumstance is, of course, the fact that she was ordered to do so by the doctor. But outlining a diet for a diabetic patient is a medical and not a nursing procedure and I believe the nurse should not have permitted such an infraction of nursing principles. Occasionally we have seen similar situations in nursing in other fields. A full-time industrial nurse, for instance, may be working under the direction of a part-time doctor. He provides her with generous blanket orders for medical treatment and we find the nurse administering blue, gray, pink, or red pills according to the nature of the worker's pain. Or in some instances, there is no doctor; the management assumes that in employing a nurse, it is providing both medical and nursing care for its workers.

We read in a recent article by a nurse: "I treat my impetigo cases" thus and so. Happily we do not see this kind of thing often. One reason this happens is because a certain type of doctor finds it convenient to delegate to the nurse certain routine jobs that would otherwise be his to do. Another reason, however, is that a certain type of nurse does not always seem able to distinguish between what is the practice of medicine and what is the practice of nursing.

A patient with any symptom of physical disorder is a patient with a *medical* need. That pain or temperature or rash must be diagnosed in its relation to other less obvious symptoms. Treatment must be outlined accordingly. There is only one person trained to do this—the doctor. He is held responsible legally, ethically, morally by the community and by his fellows for the diagnosis and the outlining of treatment of medical and surgical needs. Nursing is a separate and distinct art. The well trained nurse is an expert in the noting of symptoms and in observing the effects of treatment. She has a distinctive function in relation to the patient, that of bringing to his aid the various treatment facilities outlined by the doctor, that of removing obstacles to successful treatment and interpreting to him, in terms he can understand and apply, the lessons of health suggested by the doctor's treatment. The art of nursing a patient calls for many services and qualities from the nurse. These may range from a social service function to a highly skilled piece of physical care. It does not include diagnosis and prescription of treatment. The doctor is charged by the community, by law and by his fellows with the responsibility for knowing what fires are burning in the patient's body that manifest themselves in temperature, pain or rash. It is his responsibility and his only to outline a treatment in accordance with this knowledge. The administration of aspirin for a headache, for instance, may seem a simple and comparatively harmless procedure but it may obscure an important symptom necessary in diagnosis. A diagnosis for acute antrum infection was delayed for several days because the patient neglected to tell the doctor she was obscuring the pain he needed to know about, by copious and frequent doses of aspirin.

Is a nurse ever justified in accepting blanket orders? By blanket orders we distinguish from p.r.n. orders for an individual patient. By blanket orders we mean orders given for the prescription of certain drugs for certain symptoms such as aspirin for the girls with headaches in the workshop.

When a nurse finds herself faced with orders from the doctor such as described in the diabetic case, the execution of which could mean that she would practice medicine, what should be her procedure?

The Art of Nursing[1]

BY REV. C. B. MOULINIER, S.J.

I THINK it is somewhat cruel to me to assign me this subject, and I believe a little bit ironical on the part of our very splendid chairman to say that nobody can speak about it like myself, and yet I shall attempt to tell you a few things that have passed through my mind during the last ten or twelve years in regard to nursing, the art of nursing, and perhaps a few other phases of nursing.

All the professions are or can be characterized as arts, the art of the clergyman, the art of the lawyer, the art of the engineer, because art means the doing of something, giving of service, expression of actions that enter into our civilization in one way or another. All the arts, the beautiful arts as they are called, and the useful or helpful arts, necessarily postulate a science back of them or beneath them as a basis. Nursing, if I know the facts, is struggling toward becoming a profession—I mean a profession in the old academically accepted meaning of the word. It is not yet such in its full bloom, but every indication that I can find by reading, observing, and what I hear, points to the fact that the National League of Nursing Education, the American Nurses' Association, and the various state, county and city nurses' associations are all working toward becoming a profession similar to the profession of medicine, the profession of law, the profession of engineering, and others.

In other words, the nursing profession, as it is called, is endeavoring to so educate itself that there can be no question eventually in anybody's mind as to whether or not the group of people who take care of our sick are fully worthy of the name of profession. They give us service—a wonderful service, a service without which the poor world would lapse into misery. Are they in need of becoming a real profession? Do we humans, our race, our people of this country need a professional nurse in the full sense of the word? I think perhaps the answer to that question involves a number of differences of view and involves perplexing problems. Yet, if you ask the doctor, the best doctor, the real doctor, the doctor who thinks of his patients first, last, and all the time, who sympathetically realises what taking care of patients means today, would not he be willing to say that he wants a real, academically-trained, professional nurse? He would not be satisfied I think with a mere aid in the sickroom, a mere practical nurse, a nurse who merely does his bidding.

I think it is quite evident that the nurse is becoming more and more not alone the aid, not alone the one who follows out slavishly what she is told to do, but the nurse of intelligence, of understanding, the nurse who realises that she has a function supplementary to that of the medical man, and he welcomes her as an ally, as an associate

[1] This and the two papers following were read at the annual meeting of the College of Surgeons, Detroit, Mich., October, 1927.

in the care of his patients. Shall we think of nursing not in terms of the individual but in terms of the new hospital, the standardized hospital, the developing hospital, the hospital that is becoming better and better day by day? Shall we think of the nurse as one of a force that in alliance with the medical profession is giving a service such as was hardly thought of ten, fifteen, or twenty years ago to patients in our hospitals?

If, then, we think of the nurse as one who can be relied on, who understands thoroughly what she is doing, who appreciates every move and turn of the doctor, and who is eager to go along with him in all his growingly intricate and complex diagnoses and treatments, whatever the treatment may be, then the medical profession and all that wonderful group of women who make up what we call the profession of nursing, cannot help but want and struggle for academic recognition as a profession. They cannot, therefore, as a consequence, fail to desire that this be realized as fast as is possible and practicable; and all nurses will reach the stage of being graduated with a degree.

Can a nurse be over-educated? I think not. I do not believe anybody can be over-educated in the sense of properly educated. Can a nurse know too much? No, emphatically no. Does a nurse need a cultural background for her work? I think so. It is growing more and more a need each year. Does a nurse need to be refined and cultured? Who would dare to deny it? If the answers to these questions are what I think they ought to be, then the nurse must go on, have her high school, her college course combined with a nursing course, and get a degree.

You know better than I the complex and difficult conditions that now face the nurse in the sickroom and in the various other kinds of specialties of nursing that are developing from year to year. Why, it is amazing! The nurse of the past cannot fulfill these duties, cannot meet these demands, and yet they are coming, stronger and stronger, more complex, more exacting, day by day, and still sometimes we do hear people say—members of the medical profession and others, I am sorry to say—even at times those in the group of nurses: "Oh, we do not need any more education, just let us be bedside nurses, just let us take care of the sick, just let us do what we are told and nothing more."

If nursing is an art, as it seems to be in the minds of many (and must have been in the minds of those who gave me this title—in the mind of Dr. MacEachern, for instance, for I believe he is the guilty party) then nursing must be based on science, on exact definite knowledge, and no art is harmed by the fact that the artist has a broad and deep and comprehensive knowledge.

Truth in every one of its ramifications is bearing upon human relations, and particularly the human relations that arise between the nurse and the patient demand more and more a growing insight into the medical diagnosis and practice of today.

How can all this be gotten without a high school education, with only three years of more or less practical training? How can the mind be developed so as to understand and appreciate this vast body of underlying science and surrounding overwhelming science of today in order that the nurse may do the thing which her art demands of her to do? Art is the doing of things, the giving of a service, the giving of it with exactness, with precision, and with finish of detail, but it is more. Art is the expression

of self in all the beautiful arts, in all the practical arts. It is truly the expression of self. What has the uneducated nurse to express except a good heart, perhaps, and some fairly reliable skill? But it is not an art in itself, it is not a profession in itself unless there is a broad and sure and deep training in the science of nursing.

Hence, my plea to the national bodies of nurses is that they assume the moral responsibility, the difficulty of bringing about a training for those who enter their ranks which will bring them to the desired degree. I say I appeal to the nurses. I appeal to the national body of educators among the nurses; I appeal to all the state bodies and to the national association itself that it take into its hand as its supreme responsibility the lifting gradually, as they see it, the group of women, the great, wonderful women, to the highest plane of education.

The Carnegie Foundation reviewed medical education and set the facts before that professional body, and as an outcome we had the elevation of our medical schools from second-, third-, and fourth-rate institutions to first-rate institutions. The profession did the work after it had been pointed out that they had been neglecting a moral duty to their own profession, had been permitting any kind of person to start a medical school, turn out so-called graduates and flood the profession with inadequately trained men. You know about this. It started eighteen or twenty years ago, and all the betterment that has come since in the profession and in hospital standardisation I look upon as the logical result of that first move.

The legal profession has been treated in the same way by the Carnegie Foundation. The law schools have been surveyed and the facts set before the legal profession, and now the national and educational bodies of the legal profession are seeing to it that the schools of law are what they should be in order that they get recognition.

The same thing is occurring again through the influence of the Carnegie Foundation in the profession of engineering. I think the nursing profession know their facts. I am certain they know them well enough to start as a group of people aspiring to be a profession with developing the education, the preliminary education, and then the actual education of their people up to the point where they will be a degreed profession, and when they do it is more than likely that most of them will be artists, they will be women of knowledge, culture, refinement up to the point of real artistry. Oh, the artist nurse, the one that does things with precision and perfection, the one that does things with appreciation and personal initiative, the one that does things with imagination and feeling as well, expressing a perfect service to the sick, to the medical profession, and thus to the public!

One might go on and talk for hours almost about the beautiful artistry of a perfect nurse, of the real nurse, the profound nurse, the delicate nurse, the nurse who gives herself to the patient as a sacrificial service, just as the artist puts himself into his work and if need be sacrifices his very life for his ideal of beauty. This kind of thing we know exists. We know there are such nurses, we know there have been, but they were born. There still is the nurse of nurses being born, but the need now I think that should be emphasised is that they must be made, and that by education of a high, professional type. Then the art in nursing will be not only an art, it will be a science and it will be a profession in the full sense of those words.

The Pre-Professional Education of the Nurse

By Shirley C. Titus, R.N.

ANY discussion concerning the pre-professional education of the nurse brings to my mind a joke I heard several years ago. It seems that a man called Jones changed his boarding house. On the morning of first day's residence in this boarding house, much to his keen delight, he found corned beef hash included in the breakfast menu; the second morning found the corned beef hash again on the menu, and the third day and the fourth day. By the fifth day Jones' delight began to wane and each day thereafter found his delight dropping as does a barometer in stormy weather. Finally he reached the point where he didn't touch the hash at all but merely gave it a sickly smile and murmured: "Hebrews 13: 8." After this remark had been uttered two or three times, some of his fellow boarders became curious and wanted to know what he meant by his words. But Jones refused to answer. Finally, one had the bright thought that it was a biblical quotation and proceeded forthwith to find a Bible. Upon opening to the verse in question he found that it read: "The same yesterday, today and forever!"

Discussion of the pre-professional education of the nurse certainly belongs in the same category with the corned beef hash in regard to the frequency of its appearance. This subject was being discussed a decade or two ago and promises to occupy a place on the programs of the medico-nursing world for some decades to come.

One cannot but wonder why the educational background of the nurse seems to call forth so much discussion and interest. The pre-professional education of the dietitian, the pharmacist, the social worker, the occupational therapist—in fact any professional worker who works with the physician—does not call forth similar interest. How many times has a discussion of the pre-professional education of, let us say, the dietitian appeared on any program outside of the dietitian's association; how many articles have appeared in print relative to this subject except perhaps in the proceedings or the literature of that group? And we may ask these same questions regarding the educational background of any other profession allied to medicine, with the exception of nursing, and receive the answer "never" or "rarely."

It is extraordinary, also, that there should be this discussion of the educational background of the nurse in this country where the idea of universal education has entered into the very warp and woof of our social-political fabric. Would you not expect that in a country as education-mad as is this country of ours, the educational aspirations of any group of workers would be accepted as a matter of course, as a natural and normal desire, instead of being challenged and even actually opposed?

Why then, we may well ask ourselves, is the pre-professional education of the nurse so disturbing a matter to so many physicians? Why does it provoke so much discussion?

Upon careful thought it would appear that there are four underlying reasons why certain physicians do not look kindly on the nursing profession's desire to set as a minimum educational standard for entrance into the nursing school, graduation from an

accredited high school. I will give these reasons in what I consider the order of their importance:

(1) The physician believes such a standard will reduce the enrollment in the nursing schools.

(2) The physician feels that the more education the nurse has the more independent the nurse becomes and the less satisfactorily she is likely to meet his needs and those of his patients.

(3) The physician sees in the more highly educated nurse a possible competitor.

(4) The physician sees in the more highly educated nurse a potential judge.

Before I attempt to discuss these points I wish to say that I shall discuss them from a strictly practical viewpoint. We will think of the nurse entirely as a *means to an end* and not an *end in herself*, that is to say, we will think of her only as the worker, and ignore her as an individual with all the rights, aspirations and potentialities that every individual in a democracy, at least in theory, possesses.

(1) Will a high school education as a pre-requisite to nursing reduce the total number of nurses enrolled in the nursing schools?

To those who hold this belief I beg to say that certainly no facts or figures bear out this feeling. In fact, facts and figures seem to prove the opposite. Examine if you will the List of Accredited Training Schools in the United States; you will find that the nursing schools which maintain a standard of a completed high school education for entrance into the school certainly have the largest enrollment.

Some of the most interesting figures to be found which bear on this matter have been secured by the Bureau of Nursing Education, Wisconsin, Board of Health. Under the direction of Adda Eldredge, Director of Nursing Education, a statistical study has been prepared of the educational background of the student nurse and the enrollment in schools of nursing in that state. We find:

	1920	*1926*
Accredited nursing schools.....	43	39
Number of students enrolled....	874	1833
Students admitted that year....	328	875

In 1924, 54.33 per cent of the total number of students enrolled were high school graduates; in 1926, 76.95 per cent of the students were high school graduates. Nursing standards have been gradually raised in this state, due to the able work of Miss Eldredge and her committee, and the results speak volumes as you can see.

Such figures, plus a study of the List of Accredited Nursing Schools with figures which I am sure the Grading Committee possesses or shortly will possess, seem to confirm the contention that a higher educational standard for entrance into nursing schools which makes possible a richer curriculum and sounder instruction will tend to increase, not reduce, the nursing school enrollment.

The school of higher standards does attract more young women than does the school of low standards. This is due no doubt to the fact that the young woman who does not complete high school as a rule is the type of young woman who would prefer to enter some field where the work is less demanding, where the preparation for the work is materially shorter, and where more freedom for the individual can be found than in the nursing school: clerking, factory work, stenography, etc., are more inviting fields of work than nursing to such young women. The high school graduate on the other hand wants an education and will go where she can best secure this and hence is attracted to the school having higher standards and a richer curriculum.

We believe, therefore, that to raise the nursing school standards is not

only to increase the enrollment of the schools but to improve the quality of nursing by bringing into the profession a more intelligent and a more refined young woman. Facts and figures, as well as the actual experience of many hospitals, seem to prove that this belief is correct.

Before I pass on to a discussion of the next point I would like to say that whereas facts and figures seem to prove my last point, I am afraid that in relation to the next three points I shall discuss, I am in precisely the same position as the little boy who, asked by his teacher to give three proofs that the world is round, replied: "Cause Pa says so and Ma says so and you say so!" I cannot marshal cold facts to prove my contentions regarding the following three points. I can only tell you what nurses who have given this problem considerable thought, believe.

(2) The physician feels that the more education the nurse has, the more independent she becomes and the less satisfactorily she is likely to meet his needs and those of his patients.

I do not deny that perhaps the nurse of today is more independent than the nurse of yesterday, but this is not due to her education; it is merely a sign and symptom of the time in which we live. This is indeed the age of marked individualism. Everywhere we turn we find each person claiming for himself a maximum of the good things of life, at the same time attempting to render a minimum of service to the world. Today every one is not only sure he is as good as the next one but a lot better in fact! Youth today is totally undisciplined; youth has learned to "express itself"—it questions, it rebels, but it does not revere!

The twentieth century saw the end of the age of "the ordered society" wherein each man knew "his place"; gone are the old squirearchy days and with them the perfect servant, the careful workman, and the obedient son and daughter. For better or worse these days are gone and a new social order has taken its place—a new social order where personal independence certainly flourishes.

The "independence" of the nurse is not due to her education, we claim, but to the spirit of the times; all workers are "independent" today and do not hesitate to assert their independence. We should all appreciate the fact that it is amazing, considering the lack of stability in today's society, and the age of the student nurse, that our nurses are as dependable and reliable as they are.

Also, I am sure that the more highly educated young woman is much more likely to be coöperative and respectful and to render good service to the physician and the patient than does the less intelligent young woman. Ethics and social ideals cannot be built on ignorance or mental dullness.

(3) The physician sees in the more highly educated nurse a possible competitor.

If any physician can seriously hold such a thought as this, I believe he could not make a greater error. The nurse has her distinct function; and the physician his. I cannot see how the nurse could ever become the competitor of the physician. I have heard from time to time statements to the effect that some nurse had prescribed treatment for a patient, or had criticised the physician's orders, or had even suggested to him how to treat the patient. If these statements are true, I can only say that that nurse was certainly a non-intelligent and poorly trained nurse. No intelligent nurse would wish to assume responsibilities which she is so ill prepared to meet. We believe that no

intelligent, properly educated nurse would ever remotely desire to usurp the physician's place. Nurses realize all too clearly their peculiar function and, may I say, are distinctly proud of this function.

I believe some of the factors leading up to this feeling; namely, that the nurse *may* become the competitor of the physician, lie in the fact that from year to year, from decade to decade, the physician delegates more of his minor tasks to the nurse, as advancement in the medical art throws upon his shoulders new duties. Physicians, for example, in former years used to take temperatures, nurses were forbidden to do so; later the physician delegated this duty to the nurse as he had more and more details to handle with the progress of medicine. It is very difficult at times, even in a well organised, modern hospital to draw the line as to just exactly what is the nurse's duty and just exactly what is the interne's duty. The broad function of the two professions never change, only the execution of certain details involved in caring for the sick pass from the hands of one profession to the other.

It is absurd to think that the nurse can ever usurp the doctor's place and even if such a thing were possible, the nurse herself would be the first to object to a change in her function.

(4) The physician sees in the more highly educated nurse a potential judge.

It would appear that this feeling is more fancied than real. If any nurse openly passes judgment on the physician's work, she must be another sample of the dull, poorly trained nurse. While the more highly educated nurse might possess more grounds on which to base judgment of the physician, I believe she would be too ethically minded, as well as too sensible, to judge in such a case. She might have her private opinion of the physician or his work, even to the point where she would refuse to work with him, but I doubt if she would destroy her patient's faith in him or openly condemn him.

I feel that it is in the public health field that we find our real trouble in relation to this problem. The poorly prepared physician who is pursuing an unethical practice amongst the poor and ignorant families of the tenements does not welcome the advent of the intelligent, well trained, public health nurse. He fears her in many ways and is, therefore, inclined to go out of his way to criticize her and to look for trouble. The medical profession has already purged itself of the poorer schools; time will see the abolition of that poorly prepared physician. We have little or nothing to fear, therefore, regarding this particular point. Time will remedy it, for it is the hope of each of these two professions, medicine and nursing, to produce better and better prepared workers every year.

This, in short, constitutes what I believe to be the reasons why a portion of the medical world looks with disfavor on the nursing profession's desire to set a higher educational standard for entrance into the nursing school. Few physicians fear the nurse as a competitor or judge but far too many hold the feelings I have discussed under (1) and (2).

The nursing profession sincerely believes that the medical profession's opposition to proper educational standards for nursing is due to a lack of understanding of the matter—that it is due to prejudice based on ignorance. The nursing profession has an implicit faith in the medical profession's sense of fair play and feels, therefore, that upon being put in possession of facts, this opposition to

higher standards for nursing will disappear.

Speaking of facts makes me think of a story I heard about Pat: A drummer visited Milwaukee for the first time. Upon stepping out onto the street, the morning of his arrival, he went up to an old Irish street cleaner and said, "Pat, how large a population has Milwaukee?" Pat answered, "Shure and about 15,000." "Why, man alive, this town's larger than 15,000," exclaimed the drummer. "Oh, well," said Pat reluctantly, "Shure, and it is, if you want to count the Dutch!"

I am hoping that the medical profession will not adjust facts to their personal liking, as did Pat, but will study the situation and base their opinions on real facts, not misplaced facts.

We nurses have every reason to believe that a proper educational standard, four years of high school work, as a prerequisite for entrance to the nursing school, will increase the total number of young women who enter nursing as well as improve the quality of nursing. We want the help of the medical profession in bringing about this desirable state of affairs; I sincerely trust we may soon have it.

State Standards

By Adda Eldredge, R.N.

THE questions given me for discussion this afternoon are: "Are the state requirements for nurses too arbitrary?" and "Should the medical profession and the hospitals have a greater share in making state standards?" These questions, while very closely connected, still are quite different questions, and before making an attempt to answer them it is necessary to find out what the state requirements are, as stated in the laws, and for the purposes of this discussion, we will not differentiate between the laws and those rules and requirements issued by the governing bodies which have the force of law.

Usually, the law has two functions, the registration of nurses, and the accrediting and supervising of schools of nursing. Let us, then, first consider what are the minimum requirements for the registration of nurses as contained in the various laws, for it is on these minimum requirements for registration that the minimum requirements for entrance into schools of nursing are based.

First, age; second, education; third, graduation from "an accredited school of nursing"; fourth, the length of the training; and fifth, the size of the hospital or the daily average of patients in the hospital with which the school is connected.

In some instances, the course of study is outlined in the law, but in others left to the board to prescribe. That we may have an understanding of these legal standards, I will give a brief statistical analysis of the laws as taken from the Digest of Laws compiled in the Wisconsin Legislative Library and published by the American Nurses' Association.

Each law first deals with the existing nurses registered under waiver of examination; second, it deals with those who are eligible for examination, and lastly with those who come from other states.

Taking the age requirements for registration first, in the fifty-two

states and possessions, we have forty-two state laws requiring 21 years of age; in three the age is 20; in two it is 18; one state law requires 23 years and another 22; legal age is stated in the Mississippi law and two laws do not specify.

In regard to educational requirements, we have the following statistics: four state laws require 8th grade education; twenty-five laws require one year of high school; sixteen require two years of high school; four require four years of high school; and three, according to the Digest, do not specify the education. Here we can see definitely that the educational requirements in the laws of the majority of the states—and we are including in this study not only the states but Hawaii, the Philippines and Porto Rico, making in all fifty-two laws—are low, a fraction over one-half requiring one year of high school only; only four, about one-tenth, require four years of high school or its equivalent, and this equivalent is not uniform. It will be seen by these figures that it would take a pessimist as to the value of education, indeed, a rank believer in no education to feel that the standards for education are too high or too arbitrary, and certainly the age requirements, when in one state young women could be legally admitted to schools of nursing at the age of 15, does not seem high.

Of course, there is also the absurdity of the one law which allows a woman to take the examination but not to practice legally, that is, to become registered, until 23 years old, leaving her to practice for perhaps several years before becoming an R.N. This is probably the result of taking the R.N. to mean a title rather than a license to practice, which is what it really is and what it should be considered.

Generally, reciprocity between states is based on the law, the question being, Do the requirements of the law in one state equal or exceed the requirements of the law in another state? One state bases its eligibility on the individual's qualifications, one on its approval of the individual school.

The number of years' training required in the different laws is as follows: twenty-six laws require three years' training; two require thirty months; four require twenty-eight months; and twenty require two years.

The number of hospital beds required varies from 20 to 75 beds, one law requiring only 20 beds and ten laws requiring 25 beds. Of these ten, three do not specify the daily average of patients, five specify 20 and two require 15 patients. Eight states require 30 beds with a daily average requirement of from 15 to 25 patients. One law requires 40 beds with a daily average of 20 patients, and seven require 50 beds with a daily average stated of from 12 to 50 patients. Three states specify the daily average of patients but do not mention the number of beds. As one realises what it means to run a school of nursing with less than five nurses in a class, and 15 or less patients in the hospital, this would hardly seem arbitrary. It is unwise to base requirements on beds, and the average of patients varies at different times of the year. This must be flexible.

The third standard given in our outline was graduation from an accredited school of nursing. The determining of what these schools of nursing should be is left in most instances to the Board of Examiners. Now, how is the information which shall warrant the accrediting of the school to be obtained by the Board of

Examiners? Inspection is the only answer, questionnaires being difficult and capable of giving much misinformation. Our next study would be how this Board of Examiners is appointed. This also takes us into the question, Should the medical profession and the hospitals have a greater share in making state standards?

At present, there are twenty-three state laws which specify that the Board of Examiners shall be composed of five nurses, and sixteen laws specify that these are appointed by the governor, the other seven being appointed respectively by departments of registration, Regents in New York, Commissioner of Education, Commissioner of the District of Columbia, and in Nebraska by the Department of Public Welfare. In six laws three registered nurses are designated for the Board, which is variously appointed; thirteen laws place three to four nurses and one to three doctors on the Board of Examiners; three laws show three to four doctors and one to two nurses; two laws place no nurses at all on the Board of Nurse Examiners; two laws do not specify; two laws, those of Wisconsin and North Carolina, give definite representation from both the hospital and medical associations. In the majority of these laws the inspection is called for by members of the Boards of Examiners or by people appointed from time to time by the Boards which handle the registration. One State Board recently told me that they inspect only before accrediting, or when the graduates of a school fail in State Board examinations, or when some report comes to them in any of various ways complaining of the standards of the school. Thirteen states have full-time directors of nursing education who handle the inspection and accrediting of schools and endeavor, in so far as the authority is given them either by the law or the representative body, to help those schools to maintain the minimum standard and encourage them to reach a higher standard.

In twenty-six laws, the Board of Examiners or other administrative body decides upon the subjects for examination; in twenty-one laws the subjects for examination are specified; four laws either do not touch upon this or specify in part.

In twenty-five states the law regarding registration of nurses is compulsory; in twenty-five states it is not compulsory; and in two states the law is compulsory for public health nurses only.

We must realize in this discussion that a minimum standard is the minimum allowed and that actually the majority of the schools are far above the minimum—not from necessity but from choice. Examples: Johns Hopkins requires 21 years of age; Yale, two years of college. These are unusual requirements, but the choice of these schools.

In the matter of age and education, it would seem that the standards while arbitrary are low in the majority of instances, and could hardly be lowered or made less arbitrary.

It is a matter of personal opinion as to whether the course should be a two-year or three-year. Dealing with the supervision of schools of nursing and the administration of the law for the past six years, I believe that the age should never be below 18, that legally, that is by law, it is enough to fix the minimum educational requirement as one year of high school, and that with a one-year high school standard and the knowledge that as a rule it is the hospital with the least clinical experience which is least liable to take advantage of a two-year course, the legal requirement of two years of training is

sufficient. The better schools will know that there are certain fundamentals which the students must have and which, with the minumum age requirement, cannot be given in two years, and it will allow the governing body to insist that the small institution with a limited clinical experience must, if it has a three-year school, have affiliations. We certainly should not condemn any student to spend three years in a school connected with a 20- or 25-bed institution. To make this perfectly clear, a one year of high school requirement and a two-year training in the law seem to me to be best for a legal standard. It is hardly probable that the smaller school will attempt the two-year course because there are certain affiliations, such as children's, which must be given, no matter what the size of the institution. I believe with such a standard, and I feel we have demonstrated this in Wisconsin, the schools will keep to a three-year course, will be willing to give better affiliations and training and will increase their educational standard, not from legal necessity but to meet public opinion and to attract students. It is necessary to keep before the schools the need of giving the best training possible. I would also state that I believe no hospital with less than a daily average of 50 patients should train nurses, and not then unless they are willing to meet all of the requirements as to faculty, etc., and to give at least nine months' affiliation.

It is an interesting point that, as far as I have been able to ascertain, there is only one state which has any requirement with regard to the preparation of the woman who is superintendent of nurses. In this one instance, it is simply a statement that she must be a high school graduate, with the suggestion that she should have had some experience in teaching and some experience as an assistant. It is no uncommon thing for a young woman just graduated to take charge of a school of nursing without any preparation whatever.

With regard to the representation of the medical and nursing profession, I will say that in the actual examination of nurses, I believe the medical and hospital people have no place unless those hospital people are nurses; that representation should be given more freely to the members of the medical and hospital associations on either advisory or executive committees dealing with schools. This is sound and works well. It is a source of education and mutual understanding and, as long as hospitals are used for the training of nurses, their representatives should be listened to and their opinions taken into account, but they must be prepared to study and have an open mind and not be carried away by slogans such as "over-education."

As we look over the number of nurse boards and see that busy women have the responsibility of the administration of the law in addition to the responsibility of their own personal full-time pieces of work, there can but be decisions which are unwise, because hurried, and unless the schools are supervised there are liable to be injustices due to lack of too little supervision. When we look at the boards in which there are more doctors than nurses, it is obvious that such boards are not fair to the profession, not perhaps in their actions and decisions, but in the composition of the board; and of the two state laws which give the nurses no representation I think there cannot be one word of defense. From the fact that there are twenty-six states in which there is representation of the medical profession, and in many, of the hospitals, as on the Boards of Examiners

in some states are superintendents of hospitals who are nurses, it will be plainly seen that there is more representation than is generally believed. When only thirteen states have full-time inspectors or directors of education, it is not always a question that standards are arbitrary but that conditions are not sufficiently understood and that in many places the standards are not enforced, and I am sorry to say that in some instances, there is no effort on the part of the medical profession and the public to help enforce them, but rather an effort on the part of both groups to avoid the issue if it will cause inconvenience to the institutions which they represent.

In conclusion, it would seem that state standards are not high and that the requirements for nurses are not arbitrary, in most cases; but in answer to the second question, the medical profession and the hospital should not only have a greater share in making state standards but should take a greater responsibility as to their enforcement.

Fraudulent Agents

EARLY in December three Wisconsin members of the National League of Nursing Education reported that agents were soliciting advertising of schools of nursing and of merchants for a book said to be authorized by the National League of Nursing Education. *The League has not authorized the production of a book in Wisconsin or any other state.* It has sent letters to that effect to the directors of all the accredited schools in Wisconsin, but other states, particularly those in which year books were published in cooperation with the National League of Nursing Education a year or two ago, are hereby warned of this fraudulent activity.

National League of Nursing Education

A FULL program is scheduled for members of the League Board for the midyear sessions in January and such committees as meet at that time. The meetings begin on January 15 and close January 20. The Consultant Service Committee, Committee on University Relations, and the Education Committee will each hold a meeting during the week. The Committee on Midwifery, which also has representatives from the N. O. P. H. N., will have a conference. Joint committees of the three organizations in session will be the Bordeaux School Committee, the Robb Memorial Fund Committee, the Committee on Financing the Grading Plan, and the Committee to Study the Ideal Magazine.

The first meeting of the League Board will be held on Tuesday morning, another will take place Tuesday afternoon, and another on Friday afternoon. The joint board sessions are on Wednesday all day and Friday morning.

Department of Red Cross Nursing

CLARA D. NOYES, R.N., *Department Editor*
Director, Nursing Service, American Red Cross

Happy New Year to all.

IMPORTANT CHANGES IN FOREIGN SCHOOLS OF NURSING

HAZEL A. GOFF, who has for three years been connected with the first modern School of Nursing in Sofia, Bulgaria, has been a recent visitor at National Headquarters. About the 1st of July, 1927, Miss Goff, after two years as Director, having brought the School to a position where its direction could be assumed by graduates of the School itself, resigned. She brought the institution, during her incumbency, up to a very high standard and formed affiliations whereby the students could secure training in obstetrics and pediatrics. Perhaps the most important accomplishment was the acceptance and adoption of a constitution for the School by the Government of Bulgaria, thus placing it on a sound educational as well as political basis. Her successor, Novena Sendova, as well as the first Assistant to the Superintendent of the School, Krustanka Pachedjieva, had both following their graduation spent considerable time in this country on special scholarships preparing themselves for the positions which they now occupy. Miss Goff has accepted a position on the field staff of the Rockefeller Foundation, with headquarters at Paris; she will be responsible for the general supervision of such nursing activities as may be developed under its auspices in the Balkans. As Miss Goff speaks the Bulgarian language quite fluently and understands the languages spoken in Jugo-Slavia, she will unquestionably be a valuable addition to the Rockefeller staff. In this new capacity she will also be available as an advisor to the School in Sofia.

Mary K. Nelson who has been for the past three years Director of the American Hospital and School of Nursing in Constantinople, Turkey, resigned from that position last July and has returned to this country. She was succeeded by Alwina Francis, an American Red Cross nurse, who has spent some years in Europe and is familiar with continental affairs. Miss Nelson's connection with this School during the troublesome period of political readjustment in Turkey has been difficult, but very successful. She is now connected with the outpatient department of the Homeopathic Hospital, Providence, R. I.

THE PASSING OF HARRIET L. LEETE

THE death of Harriet L. Leete made a break in the National Committee on Red Cross Nursing Service not easily repaired. Miss Leete enrolled in the Red Cross Nursing Service before the present system of enrollment was in operation. She was number 159 on the original list. She was also one of the charter members—if one might so call it—of the National Committee on Red Cross Nursing Service. Her connection as a member had, therefore, been continuous. Early in 1914, she offered her services to the Red Cross, if nurses for the World War were needed. She was not utilised, however, until May, 1917, when as a member of the Lakeside Base Hospital unit of Cleveland, Ohio, she sailed from this country for France. This unit, it will be recalled, was the first to leave the United

States. She was temporarily loaned by the Surgeon General to the American Red Cross Children's Bureau in Paris, where she as consultant nurse gave her time to investigating and supervising the work in the districts outside of Paris. She later returned to the Army and served as Chief Nurse of A. R. C. Military Hospital Number 5. This was a tent hospital at Auteuil, an institution of strategic importance, for it served as a training center. Three hundred nurses alone passed through it in the summer of 1918, and during the first six months it cared for 11,400 American soldiers. On January 1, she was released from the Army and was assigned by the Red Cross to the Balkan Commission, and was made Chief Nurse for northern Serbia. She did a great deal in this position toward improving conditions in Belgrade and neighboring stations, and personally took an active part in cleaning up a local hospital at Palanka, where she became infected with typhus and was ill for some months. She returned to this country on July 15, 1919. Her work in this country is so well known that it need not be repeated here. In the record of her overseas duty we find the following tribute to her services:

> A ripe experience and marked ability. Her attitude throughout as well as her actual accomplishment entitled her to the highest praise.

She was decorated by the Serbian Red Cross and also received the Order of St. Sava from the Serbian Government. At her funeral and burial held at Hartfield, near Jamestown, N. Y., on November 23, the National Red Cross Nursing Service was represented by Marie Robertson, Red Cross nurse, Superintendent of the Jamestown General Hospital, who with several other Red Cross nurses attended the services.

The Admission of Nurses to Soldiers' Homes

A QUESTION has been raised in the office of the Comptroller of the Treasury in connection with the payment of certain bills for clothing of nurses who had been admitted to Soldiers' Homes which seems to raise a legal question in connection with the admission of nurses to these Homes. An informal committee, consisting of the Superintendents of the Nurse Corps of the Army, the Navy, the U. S. Public Health Service and the Veterans' Bureau, with the National Director of the American Red Cross Nursing Service and the President of the Women's Overseas Service League came together for a discussion of the situation in order to determine what steps should be taken to establish this procedure upon a sound basis which would eliminate the possibility of any questions arising which seemed to affect the admission of eligible nurses to these homes. The National Director had recently had an opportunity to visit the Soldiers' Home at Milwaukee, Wis., where most comfortable quarters had been provided for nurses suffering with tuberculosis. She was delighted to find not only excellent quarters, but a good nursing staff with fine equipment, etc. Each nurse had a room of her own, with a piazza upon which a bed could be placed for the outdoor treatment. It would be a great pity if any flaw exists in the present law which would interfere with the admission of nurses to such homes as now receive them and which are particularly adapted to their care.

New Disasters

SINCE the St. Louis disaster the American Red Cross has been connected with several others, one in Pittsburgh, where a terrible explosion

occurred, and where Miss Turnbull, formerly President of the Pennsylvania State Nurses' Association, with a group of ten nurses reached the scene of disaster within forty-five minutes after the explosion.

The serious floods in New England brought 20,000 sufferers in line for assistance. While the nursing situation has not been an acute one, still it was necessary to appoint a State Director of Nursing and in this case Mildred Whiting, the Nursing Field Representative for Vermont, was appointed. The majority of nurses were used at Waterbury. Several practical nurses were also utilized, and in other places one or two nurses were used. The majority of these nurses were volunteers; *i.e.*, serving without pay. We hear of one nurse who volunteered in a family of six diphtheria cases. It would be interesting to have more details of the experiences of the individual nurses, but in the press of work it is difficult to secure these. At Springfield, the Local Committee on Red Cross Nursing Service took charge of the nursing, and under Blanche A. Blackman, who is the Superintendent of Nurses at the Springfield Hospital, ten nurses were assigned to the care of the refugees in the Armory. The principal work in this territory will be, as was the case in the Mississippi Valley, that of reconstruction. Photographs show very sad and very discouraging pictures of destruction. The people with true New England grit, however, have set to work to help bring order out of chaos and on all sides may be heard the sound of hammer and saw.

The Red Cross had no sooner taken a long breath after these two serious disasters than a tornado struck Washington, D. C., Alexandria, Va., and other neighboring towns. Fortunately, there were few injuries, and these comparatively light ones, which were treated by the local hospitals. There was but one death in Washington, and strangely enough that was by lightning. The reconstruction work is proceeding rapidly and was not, one is grateful to say, as serious as was at first reported.

Surely the Red Cross, which is constantly fighting battles with these age-old enemies of man—fire, flood and wind—never needed the support of the people more than it does now. It is hoping for a generous Roll Call response.

Red Cross Program for State and District Meetings of Graduate Nurses

OCCASIONALLY we are asked for suggestions for Red Cross programs for nurses' meetings. An exceedingly excellent one has reached us from the Florida State Nurses' Association, which we are very glad to pass on to other nurses who may be arranging meetings of this nature:

Presiding officer, chairman of a state or local committee on Red Cross Nursing Service.

1. Salute the American Flag.
2. Reports of state and local committees.
3. Roll Call of Red Cross nurses present (by standing).
4. Plans for Delano Day in March.
5. Appoint delegate to annual Red Cross meeting.
6. Address by national or branch official, or some outstanding nurse in Red Cross Service.

Nurses for Foreign Posts

THE teaching staff at the Haitian School of Nursing, connected with the Municipal Hospital in Port-au-Prince, Haiti, will require two nurses within the next few months. One of the qualifications, in addition to experience and preparation as a teacher, is the ability to teach in French. Applicants must also be enrolled in the

Red Cross Nursing Service. For detailed information apply to the National Director of Red Cross Nursing Service, American Red Cross, Washington, D. C.

Translation of the National Health Series into Chinese

MANY nurses are familiar with the National Health Series, small booklets which have been published under the auspices of the Funk & Wagnalls Company. The Nurses' Association of China has asked permission to translate these into the Chinese language. Among these books is one on "Home Care of the Sick" or "When Mother Does the Nursing" written under the auspices of the National Director of Red Cross Nursing, with the able assistance of Frances Maltby. This little booklet is extremely practical in its nature, carrying "Johnny" through a period of illness and convalescence and should be found useful to the instructors in home hygiene and care of the sick, as well as public health nurses who may wish to refer a simple and practical textbook to women and young girls.

Enrollments Annulled

THE enrollment of the following American Red Cross Nurses has been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Bernice Alexander; Anna Louise F. Anderson; Grace Berkowitz; Hazel Shaw Blair; Susan A. Collins; Margaret Cunningham; Mrs. Elmer Crouch, *née* Edn A. Madison; Mrs. Ernest W. Darling, *née* Sadie P. Revoire; Mrs. Robert W. Davis, *née* Ethyl M. Spence; Mrs. Anna Katherine Emmes, *née* Tatting; Marguerite Mary Headley; Amy Bartlett Hebard; Mabel Janet Hendricks; Mrs. Dorothy Eveland Henoch, *née* Carter; Mrs. I. R. Heron, *née* Alta Ireland; Jessie Olive Hill; Mrs. J. G. Hilliard, *née* Ruth York O'Neal; Mrs. Elinor Porter Hodgins; Mrs. E. R. Hoff, *née* Mary Grill; Olga H. Hoffman; Madelaine Dolores Hogan; Mrs. William P. Hogan, *née* Estelle Celes Garnier; Mrs. Walter Hogg, *née* Claire Mary Malloy; Mrs. J. R. Hughes, *née* Agnes C. Snyder; Mrs. Adeline Helen Humsberger, *née* Boyd; Mrs. Eva Reavis Hunt.

Trade and Profession

"TRADE is occupation for a livelihood, profession is occupation for service in the world; trade is occupation for the joy of its results, profession is occupation for joy in the process; trade is occupation where anyone may enter, profession is occupation where only those who are prepared may enter; trade is occupation taken up temporarily until something better offers, profession is occupation with which one is occupied for life; trade makes one the rival of every other trade, profession makes one cooperative with all his colleagues; trade knows only the ethics of success, profession is bound by the sacred ties of honor." —President Faunce of Brown University.

Training Schools for Nurses

THE lack of training schools for nurses in 71 per cent of the hospitals reporting on this matter is, in the committee's opinion, largely responsible for the general inadequacy of nursing forces in county hospitals. As we have already suggested, the small hospital, that is, the one of approximately 50 beds or less, cannot maintain a training school of acceptable standard except at almost prohibitive cost, and it is doubtful if few hospitals of less than 100 beds can do so. The need for more training schools is, therefore, a strong argument for the establishment of larger hospital units. The small hospital may doubtless serve as a training school for less highly skilled nursing aids or attendants, but certainly a few county hospitals under 100 beds can provide the type of nursing education necessary to produce competent graduate nurses in all that the modern use of the term implies.—*The Bulletin of the American Hospital Association*, October, 1927.

Case Study: Erysipelas[1]

By Llouella Haage

Jersey City Hospital School of Nursing, Jersey City, N. J.

ERYSIPELAS, or St. Anthony's Fire, is an acute, specific, infectious disease of the skin and subcutaneous tissues, due to infection of the lymph spaces of the corium (true skin) and underlying parts by the *streptococcus erysipelatis* which is probably identical with the *streptococcus pyogenous*. It is characterised by both local and general signs of infection. The idiopathic form affects the face; the surgical and traumatic form invades wounds.

Erysipelas is a common disease—about ⅓ of 1 per cent of all cutaneous disorders or about 1 case in 200. Fortunately it is no longer common in surgical wards where it was at one time much dreaded. It is especially prevalent in the spring. Susceptibility is especially marked in cases of individuals with wounds or abrasions; postpartum and surgical operation cases are particularly prone to it. Alcoholism, chronic nephritis, and general debility readily predispose to it. One attack makes a patient more susceptible to another.

The form occurring around the umbilicus of the newborn is fatal; the germs are carried through the body by the blood stream causing abscesses in the lungs, spleen, kidney and the worst form of endocarditis.

Symptomatology.—Incubation period from 3 to 7 days. Most commonly found on face, usually starts on the bridge of the nose and upon cheeks, spreading over head and neck. At first, the appearance of a flush that is associated with fever and often with rigor, swelling and tension of skin increases and within twenty-four hours the external symptoms are well marked. The skin is smooth, shiny, edematous, red or reddish-purple and hot. There is some tenderness also.

The margin has a well defined raised edge which is the line of demarcation. Blebs often form on the skin, and in very severe cases abscesses may form. The eruption usually spreads rapidly, the eyes are soon closed by the swelling and the lips become swollen.

The temperature is high for four or five days, falling by either lysis or crisis. The ordinary course is self-limited and the patient usually recovers in from five to ten days.

There is a form, however, known as *erysipelas migrans* where a new focus of infection appears close to the site of the original trouble and about the time this clears up, another focus shows up. In a case of this kind the course may run for several weeks or even longer.

Complications.—Meningitis and pneumonia may occur, but rarely; septicemia and ulcerative endocarditis are more common. True nephritis is sometimes seen.

The Patient.—Male; 58 years of age; nationality, German; occupation, laborer.

From the history as given by his

[1] Read at the New Jersey League of Nursing Education Institute, Newark, N. J., January, 1927.

son, he apparently had not suffered any of the diseases so common to childhood, so that the one predisposing factor outstanding in this particular case study is chronic alcoholism accompanied, of course, by almost absolute lack of any so-called health education in his earlier life regarding hygienic living. The obvious result presented a picture of

1. *General uncleanliness of body.*—To quote the patient exactly, he had not had a bath in eighteen years for fear of catching cold.

2. *Absence of teeth.*—At age of 35, the patient was forced to have all teeth extracted due to infection, pyorrhea.

3. *Chronic constipation.*—Which again reverts to lack of health education along the lines of nutrition, exercise, ventilation, recreation, etc.

4. *Mentality.*—Developed as could be expected in an environment such as that in which this man has spent his life.

Present Specific Illness

Symptoms.—

Onset sudden with chills and fever.
Redness and swelling of nose and left cheek.
Swelling of face tends to close eyes.
Patient irrational and delirious, attempting to get out of bed—necessitating restraint.
Complaining of headache, general malaise and weakness.
Tenderness of inflamed and swollen area.

Treatment and care.—Immediately the patient was placed in bed.

(a) Erysipelas antitoxin was given intramuscularly, the dose of this standardized antitoxin being 10 c.c. (May or may not be repeated as case requires.)

(b) Line of demarcation was painted with methylene blue with collodion in the hope of checking the rapidity of new area involvement and definitely giving those in attendance the knowledge of just how rapidly the erysipelas was spreading if such were the case.

(c) Iced compresses out of a saturated solution of magnesium sulphate were applied continuously to the affected area.

(d) Ice cap to head.

(e) Magnesium sulphate was given every morning as a saline cathartic.

(f) Colonic irrigations were given daily with the hope of lessening injury to kidney tissue by the toxin produced by the causal organism.

(g) *Liquids*, chiefly water, forced, due to partial suppression of kidney activity. A very accurate table of the fluid intake and urine output was of course essential. A daily urinalysis was made.

The urine picture was quite typical: color dark amber, high specific gravity, albumin present, quantities of epithelial and pus cells.

The outstanding point in the blood picture was a marked leucocytosis. Strange to say, the blood chemistry was practically normal.

(h) In addition to these specific treatments, general nursing care including a daily bath, care of eyes, nose, mouth and ears as it is understood should be given in all febrile cases, was affected.

On administration of the antitoxin, at 2 p. m. on the day of admission, the patient's temperature was 104.6 degrees F. At midnight, a period less than 24 hours, the temperature was 101.6 or a drop of exactly three degrees. This, however, did not remain constant, rising gradually until a temperature of 104 degrees was reached on the third day when the therapeutic dose of antitoxin was repeated, causing a decrease in temperature to 101 degrees or a drop of three degrees within a period of 28 hours.

Following this second dose of antitoxin, the temperature did rise but not as high as on previous days. It continued intermittent in type for seven days, reaching a normal point but once during this period. Seven days after the administration of the second dose of antitoxin, which would be his tenth hospital day, the temperature increased to 104 degrees which was the signal of reinfection. The picture remained the same with the exception of the appearance of many blebs on the face with a profuse serous discharge from the same.

The third dose of antitoxin was administered and in approximately 28 hours the temperature dropped to subnormal, 95 degrees by rectum. The following morning there was a

normal temperature which was maintained until the date of discharge.

Due to the development of a double auricular fibrillation, the pulse was irregular, rapid, and of poor quality in the early days of the disease. This was satisfactorily controlled by digitalizing the patient, the initial dose being 2 os. of the tincture of digitalis, followed by a daily dose of 30 m. until such time as normal heart rhythm was established.

Strange to say the respiratory rate was not as high as would be expected, the highest rate being 28 per minute.

On the eleventh day with a normal temperature and a reasonably good outlook, the patient was placed on soft diet. Only one colonic irrigation was given daily. The local treatment, such as ice compresses, was discontinued as continuous treatment; they were applied for one hour, every other hour, until gradually they were dispensed with entirely when the lesions, had disappeared.

On the seventeenth day, with practically normal blood and urine picture, normal temperature, pulse, respirations and a fair amount of strength regained, the patient was discharged by the attending physician with instructions to report to the Out-patient Department once every week, bringing with him a urine specimen until further orders were given.

Bibliography.—In addition to text books used in our school, Emerson's Essentials of Medicine, Hasen's "Diseases of Skin," Jordan's "General Bacteriology," Chapin's "Sources, and Modes of Infection," Harmer's "Principles and Practice of Nursing," Roseneau's "Preventive Medicine and Hygiene."

You may ask what benefit did I, as a senior student nurse, derive from this intensive study? If I were to go into detail, I might consume too much space, but I do want to mention the many roads I was forced to retrace in refreshing my memory on *physiological points* before I could intelligently interpret the *pathological* conditions which presented themselves.

I was obliged to review parts of many courses taken in my preparatory term including:

1. Bacteriology with special emphasis on causal organisms, mode of entrance, exit, transfer and preferred lesion, primarily to render intelligent care to the patient and secondarily to protect myself and those with whom I was associated from infection.
2. Anatomy and Physiology—thorough review of the heart, blood and lymph circulatory system and particularly the skin and urinary apparatus as the chief excretory organs.
3. My lectures in Pathology which had bearings on this case, particularly those pertaining to blood chemistry, blood count and urinalysis.
4. The Red Letter Lesson in Materia Medica on digitalis.
5. The action and effect of saline cathartics on the gastro-intestinal tract.

Lastly, and of vital importance, a refreshing in my mind of the various nursing procedures involved, their purpose and expected effects.

When this case study was submitted to the training school office, the instructor in charge of case study assigned to me a conference hour at which time I was subjected to a detailed quiz on the *physiological and pathological* condition present.

I am definitely in favor of being requested by my instructors to make an intensive case study, for nothing thus far in my experience has "cinched" so efficiently and lastingly the relationship between classroom instruction and the actual practice, bedside care of the patient.

Questions

1. What is the food value of tapioca?

Answer.—A scant one-half cup of tapioca is 100 grams. The food value is P., 4 grams; C., 88 grams; F., 1 gram. In other words, the food value of tapioca is in the carbohydrate. Tapioca is excellent when used in puddings with fruit or custard, as apple tapioca pudding, orange tapioca custard, peach tapioca with custard sauce, etc. In gastric ulcer cases tapioca is used in broth and in custard. It is also used when bland foods are required for any intestinal or rectal disturbance or obstruction or in post-operative cases. In the general diet for adults or children it adds variety in desserts.

2. What articles are required for a delivery in the home?

Answer.—A valuable pamphlet, "Prenatal Care," which covers this question in detail may be had on application to the Children's Bureau, U. S. Department of Labor, Washington, D. C. The list of articles which may be required is as follows: Two to four pounds of absorbent cotton, one large package of sterile gauze (25 yards), four rolls of cotton batting, two yards of stout muslin for abdominal binders, twelve old towels or diapers, two old sheets, two yards of bobbin, or very narrow tape, for tying the cord. From these supplies the mother or nurse may make the necessary pads and bandages, which should then be sterilized. Other things that may be needed are: one hundred bichloride of mercury tablets, four ounces of powdered boric acid, one bottle of white vaselin, one pound of castile soap, one quart of grain alcohol, one douche pan, one stiff hand brush, one slop jar or covered enamel bucket, three pottery or agateware basins, one 16 inches, and two 11 inches in diameter, pitchers, at least three, holding one quart and upward, one and one-half yards of rubber sheeting, at least 36 inches wide, or one and one-half yards of white table oilcloth, to protect the mattress, one two-quart fountain syringe, one medicine glass, one medicine dropper, one drinking tube.

3. When should the doctor be called, if the patient is a multipara? How far apart should the pains be?

Answer.—There is no arbitrary answer to this question. The doctor should be notified when labor begins and his wishes in the matter should be ascertained. The end of the first stage is reached when the cervix is fully dilated, at which time the pains occur about every two minutes, are stronger and more severe, and the patient begins to feel like bearing down. With the onset of the second stage the nurse should complete the preparations for the baby's birth, bearing in mind that with a primipara the baby will not come for an hour and a half or two hours, but may come in half an hour or less if the patient is a multipara.

4. To whom does the private duty nurse's record belong?

Answer.—Dr. Malcolm MacEachern, Director of Hospital Activities for the American College of Surgeons, replies as follows: "The ownership and disposal of records is still a matter of controversy. It seems to me that the private duty nurse's record should finally repose with both the doctor and the nurse, the former in order to complete his record and keep it on file for possible subsequent use, and the nurse in case of medico-legal complications which might arise later. In other words, the doctor should have it for the future interest and welfare of his patient, and the nurse should have it for her own protection. Therefore, I would recommend that the nurse keep a copy for herself and turn the original over to the doctor if he wishes to have it.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words and should be accompanied by the names and addresses of the authors, though these need not be published.

The Delano Memorial

IF possible would you be kind enough to give in the *Journal* a report to date of what the Delano Memorial Committee has done or is doing? I know a committee was appointed to raise funds for erecting a memorial to the memory of Jane A. Delano and that quite a sum of money was collected, but for the past few years nothing has been heard of the Committee's plans and I am frequently asked if the idea of a memorial has been abandoned. I should appreciate receiving a reply through the *Journal* which, in addition to answering my inquiry, would also answer the many inquiries made to me by nurses who are interested in seeing a memorial to Miss Delano completed.

Frederika Farley.

American Red Cross,
New York

The Chairman of the Delano Memorial Committee some months ago sent letters on the present status of plans for the Memorial to all the State Associations for discussion at their annual meetings. It is assumed that the Committee will report to the Board of Directors of the American Nurses' Association at its meeting in January and any action taken at that time will be conveyed to the nurses of the country through the *Journal*. Although there have been unavoidable delays in securing a memorial, the fund is well invested and grows annually.—Editor.

Organization Membership

AFTER reading the ethical problem in the November *Journal*, I checked up on our own class of 1927. Here are the results:

Number in class	52
Number registered	42
Number examined in November	9
Number married (not examined)	1

Of the 42 eligible for active alumnae membership, 27 already have joined.

Margaret I. Fraser,
Executive Secretary,
Army School of Nursing Alumnae Association.

A Message from Oklahoma

TO nurses who are considering coming to Oklahoma in the near future to practice nursing, we would suggest that they inform themselves on nursing conditions before leaving their present locations. Oklahoma nurses do not want to seem unfriendly to the nurses from other states, but do this to save them the expense and embarrassment of finding the conditions so different from what they expected. Nurses can write the Central Registry at Oklahoma City or at Tulsa. It would be wise to enclose a self addressed envelope to be sure of a reply.

Oklahoma Nurses.

China Today

I WAS able to get up to Hankow from Shanghai a day or two after I arrived and found the city quiet excepting for the presence of hundreds of soldiers coming and going. We move about quite freely in the native city and there is now increasing activity in the business section. . . . When many of the hospitals closed down temporarily or reduced their work last spring, many of the nurses, both men and women, went into the army to do dispensary and nursing work. Several of them have visited me lately and they told pitiful tales of the treatment meted out to sick soldiers. One of the men nurses said their corps of one thousand soldiers only had two men nurses and no doctors at all. . . . Now that the Mission hospitals are reopening, the nurses are hurrying back from the army camps. Schools and colleges are still closed all through this area, but medical work is going ahead wherever there is any provision for it. Patients just crowd the dispensaries. During the absence of the foreign workers, the Chinese doctors and nurses have carried on splendidly. I was greatly encouraged on my return here to see the excellent way in which the Chinese staff, faced suddenly with heavy responsibility, had kept the work going, keeping up standards as much as possible under the very difficult conditions. I had a very heart-warming welcome back; they all told me how relieved and pleased they were. The firing of crackers and speeches of welcome were scarcely over before they gave me the keys, the papers, etc., that they had been guarding. The national examinations were drawing near, so I have been helping the nurses to prepare for it before attending to other things. Their class work was very far behind owing to the lamentable interruptions of this year. Over five hundred nurses have registered, so that means that most of the medical work throughout the country is

functioning. I wish I could tell you some of the stirring tales of heroism and loyalty amongst our nurses that I have been hearing. More than ever we realise that our best contribution to China's welfare, is to push ahead with training work, so that China's own sons and daughters may tackle the appalling task of the care of her desperately needy sick and suffering. The ravages of this unhappy year have greatly increased the suffering and destitution that already abounded on every hand. When I left for furlough, two missions that had medical work in Hankow (each possessing a small men's and women's hospital) had started to build a long-dreamed-of Union Hospital. I imagined that the troubles had put an end to the scheme, but to my surprise, I found it built and almost ready for occupation. Now, of course, we are up against a tremendous difficulty. We have the lovely new building, but no furniture or equipment whatever, and little prospect of meeting the running expenses for some time. The wealthy Chinese of the city were so robbed and many murdered during the Red régime of last spring and business men fled the city, that we cannot possibly think of raising money locally now. The obvious thing seems not to open, but that idea cannot be entertained when crowds of patients are thronging the doors of the old dispensaries and begging for treatment. The plan is to organise the previous four small schools of nursing into one Union Hospital School of Nursing. For the first time, we have nice classrooms that have been built for that purpose, and I have ventured to ask the Guild of St. Barnabas if they could help me equip the two classrooms, one as a lecture room and one as a demonstration room. May I, through the *Journal*, send a greeting to the many friends I met in the nursing world, and thank them for the kindness extended to me in that happy lovely land of America. The fragrant memories I have of my visit there will bring me joy for many a long year.

GLADYS E. STEPHENSON.

Hankow, China.

JOURNALS ON HAND

MRS. MARY E. MORROW, 417 East Capitol St., Jefferson City, Mo., has most of the numbers since 1913, which she will be glad to give away if transportation is paid.

Susie Hill, Stuart, Iowa, has copies of the *Journal* from August, 1912, to January, 1926, with the exception of seven numbers. The older numbers she will sell for 25 cents each (to 1920); the others for 15 cents each.

Amy E. Potts, 154 N. 20th St., Philadelphia, Pa., has copies of the *Journal* which she will give to anyone paying express or postage: 1912, December; 1917, January and March; and most of the numbers of the years 1923–1927.

JOURNALS WANTED

A COMPLETE file of the *Journal* is wanted for the library of the school of nursing to be established at Duke University, Durham, N. C. Address Wilburt C. Davison, M.D., Dean of the Medical School.

Last Call on Calendars

THE National League of Nursing Education announces that orders still come in for the *1928* Calendar, although it is long since out of print. Those who may want the 1928 Calendar are advised that a supply is still on hand, but orders should be placed promptly by those who think they will have use for that admirable collection of quotations. The price is $1.00 or $.75 in lots of fifty or more.

NEWS

[NOTE.—News items should be typed, if possible, double space, or written plainly, especially proper names. Send items to *American Journal of Nursing*, 19 West Main St., Rochester, N. Y.]

American Nurses' Association

NEW NURSING LAWS BRING PROFESSIONAL GAINS

Nursing bills bringing gains to the profession have been passed in many states, as results of a questionnaire sent out from Headquarters show. Legislative activities during the past year have added nursing laws or amendments to the statutes in Pennsylvania, Alabama, Georgia, Connecticut, Iowa, New York and California. Good squelching of legislation detrimental to nursing, on the other hand, has gone on in Kansas, New Jersey and Colorado. Forty-two states and two territories have answered the questionnaire thus far.

In Pennsylvania, where the nursing bill passed last April, provision is made for an additional educational director or adviser, registration is made compulsory and one year of high school is required for applicants to schools of nursing. Alabama nurses secured a law raising the entrance requirement for schools of nursing from grade school to two years of high school and provision that schools with less than fifty beds should arrange affiliation with larger schools for their students for a period of six months.

Iowa has just had a bill passed providing for the establishment of a division of nursing in the State Department of Health with a director of nursing education, and Connecticut, by law, has made it possible for small towns to secure a subsidy for public health nursing service.

The Georgia bill gives the nurses compulsory registration and allows the board of nurse examiners the authority to grant certain scientific credit for subjects taken in colleges or other branches, while passage of the Lattin Bill in New York safeguards the graduate nurse by providing that within 24 hours of the time the nurse is sent on a case, a card should be sent by the registry to her patient employer, stating whether she is a registered nurse and giving the name of the school from which she graduated and the fee schedule under which she is operating. California has made it unlawful to conduct a training school for nurses which does not comply with the requirements of the State Board of Health for an accredited school. Although the bill was passed in 1926, nurses in Washington, D. C., are still congratulating themselves over a law which provides for retirement for members of the Army and Navy Nurse Corps.

Among the bill-killers, Kansas crushed legislation which sought to abolish the State Board of Nurse Examiners, and New Jersey vanquished a bill which would have provided for registration without examination. Colorado, not very long ago, also came out successfully in a combat against a similar measure.

States which have not been pushing bills recently have not been idle. They know what they want, and are going after it. Porto Rico is out for a new bill, Tennessee is working for legislation indirectly through talks to women's clubs and civic organizations, Massachusetts is interested in securing a training school inspector, and Michigan wants a bureau of nursing, predominantly a nurses' board and the authority to plan its state program.

A chance to take a joker out of the bill is sought by Hawaii, Idaho wants to improve matters some, South Carolina is working for definite improvements, North Dakota is seeking higher educational requirements for entrance to schools of nursing, and South Dakota and Washington also want some changes.

Bills died natural and unnatural deaths in Wyoming, Missouri, and Arkansas, but nurses there are only waiting for an opportune moment to try again. Vermont is quiet for the year, Maryland is waiting for the results of the Grading Study, West Virginia is resting after a hard victory last year, Virginia is pretty well satisfied, Rhode Island feels she has an excellent bill, and many strong points are seen in the North Carolina measure.

When they are not satisfied, nurses "go to law about it," and they do it successfully.

NATIONAL TICKET OF NOMINATIONS

For the information of the states that are making up their nominating tickets, it is announced that the terms of the following members of the Board of Directors of the American Nurses expire in 1928: S. Lillian Clayton, president; Elnora Thomson, first vice president; Jane Van De Vrede, second vice president; Susan C. Francis, secretary; Jessie Catton, treasurer; Elizabeth E. Golding, Emilie G. Sargent, Mrs. Janette F. Peterson, directors. Members of the Board of Directors whose terms do not expire are: Adda Eldredge, Clara D. Noyes and Mary E. Gladwin.

Nurses' Relief Fund

REPORT FOR NOVEMBER, 1927

Balance on hand, October 31, 1927	$14,128.93
Interest received on investments	480.63
Interest received on bank balances	16.67
	$14,626.23

Contributions

Alabama: State Nurses' Association	$32.50
Arkansas: District 5	50.00
California: District 1, Alameda, $20; District 3, Humboldt County, $17; District 8, San Diego County, $20; District 15, Sonoma County, $30; District 16, Orange County, $30; District 18, Long Beach, $38; District 22, Pasadena, $25; District 24, Santa Monica Bay, $3	183.00
Delaware: State Association	7.00
District of Columbia: Sibley Memorial Hosp. Alum.	26.00
Florida: District 1, Pensacola, $21; District 3, Ocala, $5; District 7, Ft. Myers, $5; District 8, Orlando, $31	62.00
Georgia: Georgia Baptist Hosp. Alum. (1926), $33; (1927) $33; District 1, Wesley Memorial Hosp. Alum., $10; State Association, $50	126.00
Hawaii: Nurses Ass'n of Territory of Hawaii	30.00
Iowa: State Association	$577.50
Maryland: University of Maryland Alum., $68; Maryland Homeopathic Hosp. Alum., $15	113.00
Minnesota: District 2, St. Mary's Hosp. Alum., Duluth, $8; District 3, St. Andrew's Hosp. Alumnae, $16; Northwestern Hosp. Alumnae, $3; Deaconess Hosp. Alumnae, $25; St. Mary's Hosp. Alumnae, Minneapolis, $79; Fairview Hosp. Alumnae, $1; Swedish Hosp. Alumnae, $100; District 4, West Side General Hosp. Alumnae; $10; Bethesda Hosp. Alumnae, $6; individuals, $30	278.00
Missouri: Missouri Methodist Hosp. Alumnae	42.50
New Hampshire: Mary Hitchcock Hosp. Alumnae, Hanover, $10; Hillsboro County Hosp. Alumnae, Grasmere, $10; Sacred Heart Hosp. Alumnae, Manchester, $10	30.00
New Jersey: District 1, St. Barnabas Hosp. Alumnae, Newark, $10; Overlook Hosp. Alumnae, Summit, $10	20.00
New York: Contributions at State meeting, $209.25; District 1, Students Lady of Victory Hosp., $25; Buffalo City Hosp. Alumnae, $15; Children's Hosp. Alumnae, $10; Millard Fillmore Hosp. Alumnae, $25; Sisters of Charity Hosp. Alumnae, $15; Emergency Hosp. Alumnae, $5; Erie County Hosp. Alumnae, $5; Lockport City Hosp. Alumnae, $3; W. C. A. Jamestown Hosp. Alumnae, $10; General Jamestown Hosp. Alumnae, $10; Our Lady of Victory Hosp. Alumnae, $15; Mt. St. Mary's Hosp. Alumnae, Niagara Falls, $15; Mt. St. Mary's Hosp., Students, $10; Deaconess Hosp. Alumnae, $25; individuals, $16; District 2, individuals, $6; Park Avenue Hosp. Alumnae, $10; Clifton Springs Alumnae, $25; District 3, Arnot Ogden Hosp. Students, $40; Arnot Ogden Hosp. Alumnae, $25; District	

4, Students Gen'l Hosp., Syracuse, $20; Syracuse Memorial Hosp. Alumnae, 100%, $108; District 7, Faxton Hosp. Students, $5; District contribution, $25; District 9, Troy Hosp. Students, $75; Glens Falls Hosp. Students, $10; Albany Memorial Hosp. Alumnae, $50; Glens Falls Hosp. Alumnae, $10, District 11, Middletown State Hosp. Students, $15.10; City of Kingston Hosp. Students, $5; Benedictine Hosp. Students, $10; City of Kingston Hosp. Alumnae, $15; Benedictine Hosp. Alumnae, $15; District 13, Mt. Sinai Hosp. Students, $25; New York Infirmary Alumnae, $10; Lincoln Hosp. Alumnae, $10; Bulkley Training School Alumnae, $10; Fifth Avenue Hosp. Alumnae, $50; St. John's Riverside Hosp. Alumnae, $25; Manhattan & Bronx, $10; two individual gifts, $10; proceeds of card party, $1,277.28; District 14, District contribution, $225; Methodist Episcopal Hosp. Alumnae, $75; Nassau Hosp. Alumnae, $10; Prospect Heights Hosp. Students, $10; Wyckoff Heights Hosp. Alumnae, $10; individuals, $4		$2,741.63
Oklahoma: District 1, $28; District 4, $5		33.00
Oregon: Individuals		5.00
Utah: St. Mark's Alum.		14.00
West Virginia: State Association		100.00
Total receipts		$19,097.36

Disbursements

Paid to 175 applicants	$2,592.00	
Salary	100.00	
		2,692.00
Balance November 30, 1927		$16,405.36
Farmers' Loan and Trust Co.	$7,767.37	
Bowery Savings Bank	5,567.72	
National City Bank	3,070.27	
		$16,405.36

Invested funds	$116,575.87
	$132,981.23

All contributions to the Nurses' Relief Fund should be made payable to the Nurses' Relief Fund and sent to the State Chairman. She, in turn, will mail the checks to the American Nurses' Association, 370 Seventh Avenue, New York. If the address of the state chairman is not known, then mail the checks direct to the Headquarters office of the American Nurses' Association, at the address given above. For application blanks for beneficiaries apply to your own alumnae or district association, or to your state chairman. For leaflets and other information address the state chairman, or the Director of the American Nurses' Association Headquarters.

The Isabel Hampton Robb Memorial Fund

REPORT TO DECEMBER 12, 1927

Previously acknowledged	$32,456.07

Receipts

Illinois: Augustana Alumnae, Chicago	5.00
Kentucky: Deaconess Hosp. Alumnae, Louisville	5.00
Nebraska: State Association, $25; District 1, $5	30.00
Tennessee: State Association	20.00
West Virginia: State Association	10.00
	$32,526.07

MARY M. RIDDLE, *Treasurer.*

The McIsaac Loan Fund

REPORT TO DECEMBER 12, 1927

Balance, November 11	$1,060.17

Receipts

Illinois: Augustana Alumnae, Chicago	5.00
Nebraska: State Association, $25; District 1, $5	30.00
Tennessee: State Association	20.00
West Virginia: State Association	10.00
Loan repaid	200.00
	$1,325.99

Expenditure

Two loans, $200 each.....	$400.00
One loan, $100.....	100.00
	$500.00
Balance, Dec. 12.....	325.99

MARY M. RIDDLE, *Treasurer.*

Checks should be made out separately and sent to the treasurer, Mary M. Riddle, care *American Journal of Nursing*, 19 West Main St., Rochester, N. Y. For information or application blanks, write the secretary, Katharine DeWitt, at the same address.

Army Nurse Corps

During the month of November, 1927, orders were issued for the transfer of members of the Army Nurse Corps to be stationed as indicated: to Fort Monroe, Va., 2nd Lieut. Nell Suggs; to Letterman General Hospital, San Francisco, Calif., 2nd Lieut. Lulu J. Newton; to the Philippine Department, 2nd Lieuts. Margaret Uthaug, Ethel E. Peters.

Fourteen have been admitted to the corps as 2nd Lieutenants.

The following named are under orders for separation from the Corps: Adeline P. Boren, Mary A. Campbell, Lonnie C. Copenhaver, June H. Howard, Annamarie Koch, Mae E. Rathbun, Elsie J. Wigga.

JULIA C. STIMSON,
Major, Army Nurse Corps,
Superintendent.

Navy Nurse Corps

REPORT FOR NOVEMBER, 1927

During the month of November, ten nurses have been appointed and assigned to duty.

Transfers: To Annapolis, Md., Rachel K. Mytinger; to New York, N. Y., Margaret M. Welsh; to Parris Island, S. C., Marjorie E. Wheeler; to Philadelphia, Pa., Navy Yard, Nell I Disert, Chief Nurse; to Puget Sound, Wash., M. Ada Allen; to U. S. S. "Mercy," Helen A. Russell, Chief Nurse, Audrey B. Hurd, Ruth F Snell, A. Gertrude Klesius, Laura Hartnell, Rose Anna Soucy.

The following nurses have been separated from the Service: Laura T Stinnette, Julia A. Polta, Willie E Pryor, Clara B. Holladaye, Katheryn Flesh.

J. BEATRICE BOWMAN,
Superintendent, Navy Nurse Corps.

U. S. Public Health Service

REPORT OF THE NURSING SERVICE FOR NOVEMBER, 1927

Transfers: To Baltimore, Md., Mary Shappacher, Georgia Adkison, Abbie Riggin; to Boston, Mass., Christine O'Rafferty, Rava H. Kelly; to Portland, Maine, Orpha Dudte, Anna Dudte; to Stapleton, N. Y., Mary R. Swann, Marie Tilley; to Hudson St., New York, Marion Reid; to Richmond, Ky. Margaret Jones.

Reinstatements: Marie Niklaus, Irene B. Gurney, Mary Brady, Margaret Adams, Josephine T. DuBois.

New assignments: Seven.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

U. S. Veterans' Bureau

REPORT OF NURSING SERVICE FOR NOVEMBER, 1927

New assignments: Forty.

Transfers: To Sunmount, N. Y., Clara Spielman; to Ft. Lyon, Colo., Nellie Hayes; to Ft. Snelling, Minn., Jennie Hansen; to Tucson, Aris., Edna Dunnan; to Bronx, N. Y., Clara Wilt; to St. Cloud, Minn., Kathleen Dorsey, Chief Nurse; to Livermore, Calif., Eleanor Vogel; to Waukesha, Wis., Helen Wilke; to Augusta, Ga., May Nugent, Chief Nurse.

Reinstatements: Lake Simpson, Serene Aarrestad, Wilhelmina Wilson, Hazel Dickison, Mary V. McCarthy, Ruth Young, Margaret Warren.

MARY A. HICKEY,
Superintendent of Nurses, U. S. V. B.

National Council of Women

At the fourteenth convention of the National Council of Women, held in New York, December 5-10, Miss Clayton was unable to represent the American Nurses' Association on Presidents' Night, but she was represented by Lydia E. Anderson. On December 9, at the luncheon of the Committee on Public Health, Mary Beard and Elizabeth G. Fox were the speakers. On the same afternoon, Mary M. Roberts spoke on "Nursing—an Adolescent Profession."

Catholic Hospital Association

THE CATHOLIC HOSPITAL ASSOCIATION will hold its thirteenth annual convention, June 18–22, at the Music Hall and Auditorium, Cincinnati, Ohio.

Commonwealth Fund Staff Changes

Alma C. Haupt, Assistant Director of the Division for Austria, has been transferred to the staff of the New York office, where she will commence work with the Division of Rural Hospitals in direct charge of the nursing and public health service of the Division. Theresa Kraker, who has had charge of this work temporarily, pending the return of Miss Haupt from Austria, is continuing with the Fund as Supervisor of Nursing for the Child Health Demonstration Committee, and as special assistant in public health. Hortense Hilbert, previously Executive Assistant in Austria, has succeeded Miss Haupt.

International

THE POLISH NATIONAL ASSOCIATION OF PROFESSIONAL NURSES

The Polish National Association held its second annual meeting in Warsaw, October 21–23, with an attendance of eighty members and with one hundred and fifty to two hundred present at the open meetings, including prominent physicians and non-professional nurses. In 1921, there were only three graduate nurses in the country; now there are 169. Some of the subjects discussed were: "Some Essentials in Nursing Education," Helena Bridge; "Possibilities in the Development of Nursing in Poland," Marja Babicka; "The Field of Nursing Activities," Dr. M. Kasperzak; "The School Nurse," "The Nurse in the Tuberculosis Dispensary," "The Work of the Public Health Nurse in Posnan," "The Lack of Trained Public Health Nurses," "The Hospital and the School of Nursing," "Some Remarks on the Nursing of Children," "English Schools of Nursing." There were excursions to the Health Centre, Amelin, to the State School of Hygiene, to the Gynecological Clinic and to the Jewish School of Nursing. A reception was given at the Warsaw School of Nursing.

MORE CONVENTION PLANS ANNOUNCED

Nurses' official registries, group and hourly nursing, are three subjects which will receive special emphasis at the Biennial Convention of the American Nurses' Association, June 4 to 9, at Louisville.

General sessions will be held on Tuesday and Wednesday, June 5 and 6, at the Rialto Theatre, and sessions with the National League of Nursing Education and the National Organization for Public Health Nursing will be held at the Armory which will be the headquarters of the whole convention.

In the *Journal* for February, announcement will be made of the transportation facilities to Louisville, including railroad and special automobile routes.

Dr. William Russell's Inauguration as Dean

TAKES THE PLACE OF ALUMNI DAY AT TEACHERS COLLEGE

This year there will be no official Alumni Day at Teachers College in February, but instead an invitation will be extended to Alumni of Teachers College to attend the inauguration of Dean William Russell which will take place April 10 and 11. There will be a two-day program consisting of addresses from visiting representatives of other universities and other special features with a dinner on the evening of the 11th. The various departments will arrange programs for Wednesday afternoon, at which they will confer with former students and other outstanding people in the professional field to discuss present programs and how they can be made to meet their needs more effectively.

Indian Bureau

Appointments: Nine.
Resigned: Four.
Reinstated: One.

ELINOR GREGG,
Supervisor of Field Nurses.

Conferences, Institutes or Summer Schools

CONFERENCE ON NURSING SCHOOLS CONNECTED WITH COLLEGES AND UNIVERSITIES

This conference, held under the auspices of the Department of Nursing Education,

Teachers College, and the Committee on University Relations of the National League of Nursing Education, will be held at Teachers College, Columbia University, New York, January 21, and January 29–25.

January 21, Teachers College Chapel.

10 a. m. to 12.30 p. m. Chairman, Miss Nutting. *All who are interested are invited to this session.*

Greetings, Dr. William F. Russell, Dean of Teachers College, and Carrie M. Hall, President National League of Nursing Education. "Historical Summary of the Relations of Nursing Education to Universities," Miss Nutting. "The Progress of Professional Education under University Auspices," Dr. James E. Russell, Dean Emeritus, Teachers College. "Relation of Medical Education and Nursing Education," Dr. Canby Robinson, Dean, School of Medicine, Vanderbilt University, Nashville, Tenn.

2.30–4.30 p. m. Chairman, Annie W. Goodrich.

"The Relationship of the Medical School to the Hospital," Dr. William Darrach, Dean, College of Physicians and Surgeons, Columbia University. "The Relationship of the Medical School and Nursing School in a University," Dr. M. C. Winternitz, Dean Yale University Medical School. "The Relation of Nursing Education to Current Educational Movements," Dr. Robert Leonard, Director School of Education, Teachers College.

An informal reception in the Grace Dodge Room, 104 Dodge Hall.

January 23–25, Group Conferences.

This part of the Conference is designed for free and informal discussion which can be carried on only in small groups. For this reason attendance is restricted to representatives of the nursing profession who are conducting Schools or Departments of Nursing connected with Colleges or Universities. Admission will therefore be by *invitation only*. All sessions will be held in Room 105 Dodge Hall, Teachers College.

Monday, January 23, 10 to 12.30 a. m., *Administration of University Nursing Schools*, in charge of Miss M. A. Nutting and Miss Carolyn Gray.

The Relationship of the Nursing School to the Hospital, University, Junior College and Other Possible Units. Administrative Officers and their Relationship. Division of Responsibilities and Functions. Coöperative Adjustments.

2 to 4 p. m., *The Cost of Professional Education in University Schools of Nursing*, in charge of Annie W. Goodrich.

The Educational Budget, How and by Whom Prepared. The Cost of Nursing Service. Sources for Financial Support of the Nursing School. The Cost of a University Nursing Course to the Individual Student.

Tuesday, January 24, 10 to 12.30 and 2 to 4, *The Curriculum of the School of Nursing Connected with a College or University*, in charge of Katharine Tucker, Chairman of the Education Committee of the National Organization for Public Health Nursing and Isabel M. Stewart, Chairman of the Education Committee of the National League of Nursing Education.

Different Types of Programs Offered in University Schools or Departments. The Combined Liberal Arts and Professional Program—Objectives and Content. The Arrangement of Theory and Practice in such a Program. Administrative Problems in Arranging Student Schedules. The Basis for Accrediting Theoretical and Practical Work. The Place of Public Health Nursing in the Programs of University Schools and Departments.

Wednesday, January 25, 10 to 12.30 and 2 to 4, *Standards for Evaluating the Work of a University School of Nursing*, in charge of Carolyn Gray, Chairman, Committee on University Relations of the National League of Nursing Education and Elizabeth C. Burgess, Professor of Nursing Education, Teachers College and formerly Secretary of New York State Board of Nurse Examiners.

Basis of Evaluation for University and Hospital Resources and Standards. Admission Requirements. The Faculty—Preparation and Status. Standards of Teaching and Supervision. Standards of Student Work and Graduation. Living and Working Conditions—Extra-curricular Activities.

Commencements

Pennsylvania: Braddock.—The Braddock General Hospital, a class of ten, on October 18, with an address by Hon. M. Clyde Kelly.

Virginia: Staunton.—The King's Daughters' Hospital, a class of five, on December 6, with an address by Flaridus Crosby.

State Boards of Examiners

Arizona: The Arizona State Board of Nurse Examiners will hold a meeting at

Phoenix, January 20. Catherine Beegin, Secretary.

Iowa: Mrs. Margaret Stoddard of Mt. Pleasant has been appointed to succeed Jane M. Wiley on the Board of Nurse Examiners. Frances G. Hutchinson of Council Bluffs is President, and Marianne Zichy of Marshalltown is Secretary.

Mississippi: The Mississippi State Board for Examination and Registration of Nurses will hold an examination for state registration in Jackson, January 2–3. Applications for this examination should be filed not later than December 15, with the Secretary of the Board, Maud E. Varnado, Hattiesburg.

Missouri: The Missouri State Board of Nurse Examiners will hold its next examination in St. Louis and Kansas City, February 15 and 16. Jannett G. Flanagan, Secretary.

Nebraska: Phoebe M. Kandel, a graduate of the Lakeside School of Nursing, Cleveland, and of Teachers College, became, on January 1, Educational Director (State Board of Nurse Examiners). Miss Kandel has held various teaching and administrative positions, notably at the Jewish Hospital and at the University School of Nursing, Cincinnati, and the New Rochelle Hospital, New Rochelle, N. Y.

State Associations

California: The annual conventions of the California State Nurses' Association, State Organization for Public Health Nursing, and the California League of Nursing Education will be held in Riverside, June 25–29.

Connecticut: The Graduate Nurses' Association of Connecticut held its fall meeting in Stamford on October 27. The Section Meetings were held in the morning at the Nurses' Home of the Stamford Hospital. The Educational Section had for its subjects: Extra-curricular Activities, Rachel McConnell; and the "Educational Program in the High Schools Relating to Welfare Work," by Mrs. Winifred Hart. The Public Health Section had for its speaker, Maude Kestor, Director of Special Education and Standards, Connecticut State Board of Education, her subject being "Children Who Are Different." The Private Duty Section discussion was, "Mental Hygiene and the Private Duty Nurse," by Hester Crutcher, Executive Secretary of the Connecticut Mental Hygiene Society, and "Private Duty Nursing, My Choice," Elisabeth Somers. At the Board Members' Division meeting, Sarah Addison, Director of the Bureau of Public Health Nursing of the State Department of Health, was the speaker. Following the meetings a delightful luncheon was served by the Stamford Hospital. The afternoon session was held at the Women's Club Building. A most cordial welcome was extended by Dr. Raymond D. Fear, Commissioner of Health. Dr. C. E. A. Winslow of Yale University gave an inspiring talk on "Why the Grading of Nursing Schools." Following the business meeting, Miss VanPatten gave a report of the American Public Health Association meeting recently held at Cincinnati. After adjournment tea was served by the Stamford Visiting Nurse Association.

Delaware: The fall meeting of the Delaware State Association of Graduate Nurses was held November 17 in the Parish House of St. Andrew's Church, Wilmington. The afternoon meeting at which Amelia Kornbau presided, was devoted to business. A public health round table preceded it. At the evening session, Susan C. Francis of Philadelphia gave an interesting account of her trip to Switzerland to attend the International Council of Nurses.

Florida: The fourteenth annual convention of the Florida State Nurses' Association was held at Miami, November 3–5. Headquarters was Hotel Everglades, where one hundred and fifty-four nurses registered, the largest number who have ever attended for the full time of the convention. The program was so arranged that it held the attention of all nurses regardless of the division of work in which they were most interested. Thursday, November 3, Morning session, business, Byrtene C. Anderson, presiding. Invocation by Rev. C. H. S. Burgin; address of welcome, Hon. E. G. Sewell, mayor of Miami; response, Kathryn Gutwald, West Palm Beach. Reports of officers and of districts, of the secretary of the State Board of Health and the president's address were given. A business session was then conducted at which time a number of matters to be discussed were handled. $150 was allowed for the delegates' fund to the national convention in June. It was recommended to the A. N. A. that a newsletter be mailed to the state secretary, who in turn would mail it to the district secretaries, this newsletter to take the place of Anagrams. It was decided to send $25 to the Florida Children's Home Society. The treasurer was instructed to send

five cents per member to the A. N. A. as membership dues to the International Council. A new district is to be formed which will be known as District 14 with Ft. Lauderdale as nucleus. In the afternoon a general session was conducted by the Red Cross, Julia Kline, Secretary, Miami Committee, presiding. Salute of the American Flag; reports of state and local committees; roll call of Red Cross nurses present; plans for Delano Day in March; appointment of delegates to the annual Red Cross meeting; an address, "The American Red Cross and the Nurse," I. Malinde Havey, Washington, D. C. Other papers followed: "Objectives of the State League of Nursing Education," Louise B. Benham, Secretary; "The Nurses' Relation to the Patient and the Physician," John A. Simmons, M.D., President, Florida State Medical Association. The entire evening was given to Janet M. Geister, Executive Secretary, American Nurses' Association, who discussed "The Nurse and the Community." This meeting was open to the public and was well attended. A dinner dance was given by the American Legion and was most enjoyable. On Friday, November 4, a general session was conducted by the Public Health Section. M. F. Bishop, chairman. After old and new business, the following papers were presented: "Coöperation," B. L. Arms, M.D., State Health Officer; "Communicable Disease Control," W. A. Claxton, M.D.; "Avoidance of Communicable Diseases among School Children," Nancy Lawler, West Palm Beach; "Public Health from the Juvenile Court Standpoint," Judge Edith M. Atkinson; "Your Opportunities," Beatrice Short, Assistant Director, National Organization for Public Health Nursing; discussion, "Question Box Feature." Election of officers for the Section. In the afternoon a general session was conducted by the Private Duty Section, Evangeline Wilder, Miami, presiding. After reports of committees there followed "The Nurse in the Changing Order," Janet M. Geister. Since there was very little business the time was given to Miss Geister. The following Section officers were elected: Chairman, Olive E. McMullen, Tampa; secretary, Buena Stevens, Tampa. At 4.30, there was a visit to the Jackson Memorial Hospital and a tea at the Woman's Club. Saturday, November 5, Morning session, business. The election of officers was as follows: President, Mrs. Julia W. Kline, Miami; vice presidents, Jessie Lee Gross, Miami, and Fairy Quinn, Lakeland; secretary, Mrs. Bonnie Arrowsmith, Tampa; treasurer, Bertha Rowe, Daytona Beach. At noon, the members enjoyed a "Se-Bottom Boat" Trip, courtesy of the Chamber of Commerce. At the board meeting following the annual meeting, Tampa was selected as the next meeting place. The chairman of the Red Cross Committee for the year was appointed, Mrs. Arrie Allen Lambert, Miami. Mrs. M. F. Bishop was named as delegate to the Social Workers' Council to be held in Lakeland.

Georgia: The twenty-first annual convention of the GEORGIA STATE NURSES' ASSOCIATION was held in Macon, November 8–10, and has been pronounced the best convention ever held by this organization. Janet M. Geister, Director of Headquarters of the American Nurses' Association, Ruth Mettinger, Field Representative of the A. R. C. for Georgia and Florida, Dr. W. A. Mulherin, President of the Medical Association of Georgia, Beatrice Short of the N. O. P. H. N., and others were guests of the Association and contributed to the various programs. The only note of sadness was the absence of Lucy M. Hall, of Savannah, the beloved and retiring president of the Association. Margaret Dorn of Augusta, first vice president, presided. Annie Bess Feebeck of Atlanta was elected to succeed Miss Hall. A meeting open to the general public was held Tuesday evening, November 8, in the beautiful new city auditorium, being well attended by nurses and lay people. A large student body attendance from the several local hospitals added a great deal to the impressiveness of the occasion. Janet M. Geister and Dr. W. A. Mulherin were the principal speakers, and the program centered around service to the sick, as viewed by the patient, the doctor and the nurse. Others who contributed to this program were Dr. M. A. Clark and Mrs. Walter D. Lamar, both of Macon, and Agnes P. McGinley of Athens. The morning session, Wednesday, November 9, was turned over to the State League of Nursing Education, and Mrs. Eva S. Tupman of Atlanta presided. The program comprised a symposium, "The Small Hospital and School of Nursing," Dr. A. R. Rosar of Oglethorpe Infirmary, Macon, giving a paper on the advantages of the small hospital in training student nurses for service to patients and the community in which they live. Shirley Hamrick of Cedartown spoke on "The Advantages of Affiliated Courses in the Small School of Nursing," and Annie Bess Feebeck, Atlanta, contributed a paper on the "Advantages of Affiliated Students to the Large Hospital School of Nursing." "Developing the Resources of the Community" was the topic of a paper by Jane Van De Vrede, Executive Secretary of the State Association. New

officers elected to the State League of Nursing Education were Jessie M. Candlish of Atlanta, vice president; Annie Bess Feebeck, reëlected as secretary; and Lillian Alexander of Atlanta, director. Mrs. Tupman was elected in 1926 to serve two years as president. The Private Duty Section convened Wednesday afternoon, with Jean Harrell of Atlanta presiding and giving a special message. Among the speakers were Lucy B. Wright of Asheville, N. C., a missionary nurse on furlough from China, who talked most interestingly on nursing conditions in that country; Lucia Massee of Cuthbert, and Vera Mingledorf of Savannah. Miss Massee and Miss Mingledorf chose for their subjects "What the Nurses' Registry May Expect of the Nurse" and "What the Nurse May Expect from the Registry," respectively, and discussion of these subjects followed. Jean Harrell was unanimously reëlected as chairman of the Private Duty Section, and Mrs. Sue M. Paillee, Atlanta, was elected as secretary. Thursday morning's session was devoted to the first annual meeting of the State Organization for Public Health Nursing, and was presided over by Lillian Alexander, Atlanta, in the absence of Virginia Gibbs, president. Mrs. Myra Cloudman, director of the Athens Child Health Demonstration, Athens, was the principal speaker, her paper on "Public Health Nursing" being illustrated with charts. Mrs. Frank Schley of the Columbus Public Health Nursing Association, and Frances Hall of the Elberton puplic schools, also added a great deal to the program with papers on developing the cultural resources of the public health nurse and with the study of special psychiatric clinic problems. Rhoda Kaufman, Executive Secretary of the State Department of Public Welfare, gave a highly interesting depiction of the work of this Department, and plead for the closest of coöperation between the public health nurses and this Department. After reports of officers and committees, the following officers were elected to serve the coming year: Louise Hasleburst of Macon, president; Mrs. Estella C. Westcott, Savannah, and Lillian Alexander, Atlanta, vice presidents; Carroll Swann of the State Department of Health, secretary; and Mrs. Anne Rivers of Savannah, treasurer. Beulah Carrington of Dalton and Virginia Gibbs of Marietta were elected as nurse members of the Board of Directors and Mrs. J. J. Egan of Atlanta and Mrs. Bruce Carr Jones of Macon as non-nurse members of the Board. An hour devoted to the American Red Cross was a bright feature of Thursday, November 10, from 11.30 to 12.30 a. m. Emma Dozier, Chairman of the State Committee, could not be present, and Miss Van De Vrede was asked to preside. Ruth Mettinger, Nursing Field Representative for Georgia and Florida, was present and spoke in the interest of present activities of this organization, urging coöperation of the nurses in the eleventh annual roll call. Lillian Cumbee of Atlanta was nominated to succeed Miss Dozier as chairman of the State Committee and elected as delegate to the A. R. C. Convention in Washington, D. C., December 7. Local reports indicated continued interest in Red Cross enrollment, and the formation of a new local committee was taken up. The last and business session of the convention took place on Thursday afternoon, at which time new officers for the coming year were elected: President, Annie Bess Feebeck, Atlanta; vice presidents, E. Alma Brown of Augusta, and Jessie Veazey of Atlanta; secretary, Mrs. Alma Albrecht of Savannah; treasurer, Jane Van De Vrede; Hattie Wilder of Macon is the new counselor, succeeding Miss Feebeck. Other business transacted at this session included instructions regarding the naming of delegates to the biennial convention of the American Nurses' Association, and acceptance of the report of the A. N. A. Nominating Committee. Greetings from several state associations and individuals were read at this meeting, and the new officers were given formal introduction. The 1928 convention will be held in Columbus. The social features of the convention were altogether delightful. Mrs. Mae M. Jones, president, and the Third District organization of nurses were official hostesses, and Dora Kirshner of the Macon Hospital was chairman of local arrangements.

Illinois: Officers of the ILLINOIS STATE ASSOCIATION are: President, Irene R. Stimson, Rockford; vice presidents, Charlotte Johnson, Chicago, Hattie Hurst, Joliet; secretary, Ella Best, Chicago; treasurer, Mabel M. Dunlap, Moline. The chairman of standing committees are: Arrangements, Myrtle Chalstrom, Joliet; Credentials, Beatrice M. Clutch, Quincy; Finance, May Kennedy, Chicago; Legislative, Alice E. Dalbey, Springfield; Nominating, Laura M. Burnett, Urbana; Program, Anna D. Wolf, Chicago; Publicity and Press, Katharine J. Densford, Chicago; Red Cross, Mary Garretson, Winnetka; Revision, L. Maude Ryman, Jacksonville; Relief Fund, Lillian Thompson, Chicago; Tuberculosis, Alice M. Hefner, Chicago. Chairman of Sections are: Public Health, Mary A. McKay, Peoria; Private Duty, Blanche Hanson, Peoria.

Iowa: Maude E. Sutton, Mason City, has been appointed to the position of State Director of Nursing Education to succeed A. Faith Ankeny, who, as Acting Director, has given so freely of herself in carrying on the work for nearly a year. Miss Sutton is a graduate of Iowa Methodist Hospital, Des Moines, and has had experience in private duty, public health and institutional nursing work.

Louisiana: The eighth annual convention of the LOUISIANA STATE NURSES' ASSOCIATION was held in Baton Rouge, October 26 and 27, with headquarters at the delightful new Hotel Heidelberg. It is worthy of note that the business sessions were held in the State House, where an address of welcome was given by Governor Simpson, following which, Dr. Lester J. Williams welcomed the members on behalf of the Parish Medical Society. Mrs. A. L. Smith gave greetings as President of the Baton Rouge District. The response was given by the State President, Geneva A. Peters. The principal business before the house was a revision of the state charter and by-laws, with the all-important subject of a home for aged nurses. This latter, however, was referred to a committee which will look up data on the matter in an effort to draw up some working plan. Some excellent papers were read, Mrs. Lydia Breaux and Julie C. Tobo taking care of the Red Cross Section. Some interesting flood experiences were given, and Miss Pagaud of New Orleans, and Beatrice Short from National Headquarters discussed Public Health work. Dr. Ralph Hopkins, Tulane University read a most instructive paper on leprosy, and showed a number of slides. One of the features of the Convention was a trip on the last evening to the Leprosorium at Carville, where all were delightfully entertained by the Sisters in charge. The Baton Rouge nurses did themselves proud in the way of entertaining, and looking after the comfort and pleasure of the visiting nurses. They were taken to the Louisiana State University where they were shown all its beauty and efficiency. Too much cannot be said in praise of those who planned the charming details of the dinner given at the Westdale Country Club. Mention also must be made of the delicious luncheon served by the Standard Oil Co. in the dining room of their plant, in the suburbs of the city. This convention will go down in our history as one of the most enjoyable ever held. Each district was well represented, thirty or more being present from New Orleans among whom was the newly elected State President, Mrs. Clara C. McDonald. Hospitality was also shown by the Sisters in charge of Our Lady of the Lake Sanitarium in Baton Rouge. There was discussion regarding a three-day session for future meetings, some arguing that too much time is always spent in pleasure, others saying that nurses need the playtime thrown in between the business sessions. However, it was decided to finish the work in two days, curtailing the entertaining, rather than the business, if necessary. The election of officers finished the business, and the convention adjourned from the State House where a few short years ago some of the visiting nurses had been representatives from their districts to work for registration for nurses, which at that time seemed hard of attainment. Officers elected are: President, Mrs. Clara McDonald, New Orleans; vice presidents, M. McGeehee, Patterson, and Mrs. Annie L. Smith, Baton Rouge; secretary, Susie Collins, New Orleans; councillors, Geneva Peters, Dorothea Macheuse, Maud Reid. Chairmen of committees are: Legislative, Barbara Frank; Program, Mrs. I. V. Haley; Publication and Press, Ethel V. Monroe.

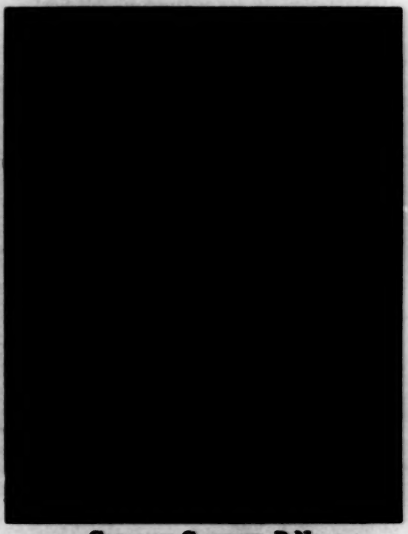
THE LOUISIANA LEAGUE OF NURSING EDUCATION held its third annual meeting in Baton Rouge, at Our Lady of the Lake Sanitarium, on October 26, in conjunction with the Louisiana State Nurses' Association. The program included an instructive talk by Dr. Ellen A. Reynolds, Head of Department Home Economics, Louisiana State University, on the "Opportunities of Graduate Nurse in College." Dr. Reynolds stated that the registered nurses have done and are still doing excellent work, but present-day progress makes demands for women with a broader educational viewpoint. The round-table conference presided over by Sister Kostka, gave additional information on Schools of Nursing Topics. The work of the Grading Committee was again brought forth with new emphasis by Julie C. Tobo, Secretary of the Nurses' Board of Examiners, who urged the members of the League to cooperate by returning the blanks with the desired information to headquarters of the committee. A report on a State Standard Curriculum for Louisiana was presented for adoption, by Mrs. Annie L. Smith. Affiliation in general was discussed by Willie Pilgo of Monroe. At the business session, the League pledged financial assistance, according to its means, to the Grading Committee. The new officers elected are as follows: President, Marian Sloan, New Orleans; directors, L. A. MacGahan, Patterson and Mrs. T. Martin, Shreveport. A banquet at the Nurses' School of Our Lady of

the Lake Sanitarium was held in the evening followed by a very entertaining concert.

Maine: The annual meeting of the MAINE STATE NURSES' ASSOCIATION will be held at the State House, Augusta, January 6 and 7.

Mississippi: THE MISSISSIPPI STATE ASSOCIATION OF GRADUATE NURSES met in Meridian, October 27 and 28. The outstanding features of the meeting were as follows: The name of the Association was changed to Mississippi State Nurses' Association. The fiscal year was changed to January 1 to December 31, inclusive. Several amendments were recommended to come before the next Legislature. The Association had gained one hundred and three new members during the year. It was voted to send $25 to the Relief Fund, in addition to individual donations, also to send $25 to the Grading Committee, in addition to individual contributions. A rising vote of thanks was given to the American Red Cross for its work during the flood. During the year, the Association became affiliated with Mississippi Federation of Women's Clubs. I. Malinda Havey, and Helen Dunn, of the American Red Cross, and Beatrice Short of the National Organization for Public Health Nursing contributed to the success of the meeting. Officers elected are: President, Rose Keating, Jackson; secretary, Mary D. Osborne, Jackson.

New York: LYDIA E. ANDERSON INSTRUCTORS' LOAN FUND. In May, 1927, a group of friends and former students of Lydia E. Anderson, at a dinner given in her honor in New York City, presented her with a sum of money to be known as the Lydia E. Anderson Fund, in recognition of her contribution to nursing education through her years of teaching in schools of nursing. At the annual meeting of the New York League of Nursing Education, Miss Anderson handed this sum over to the League to be held by that organization as a loan fund for nurses preparing themselves to be instructors in schools of nursing. This fund will be administered by a committee of three, the chairman of which is the treasurer of the New York League of Nursing Education. The other members of the committee, as appointed by the Board of Directors after the annual meeting, are Lydia E. Anderson and Isabel M. Stewart. It is hoped that the fund may attract other gifts as time goes on, and that by keeping it in circulation the League may be able to help many nurses desiring assistance in their efforts to prepare themselves to teach in schools of nursing. The sum is now available in small or in larger amounts. Applications should be sent to either the President or the Treasurer of the New York League and will be given due consideration by the committee.



CAROLINE GARNSEY, R.N.

Caroline Garnsey, R.N., who, on December 1, became Executive Secretary of the New York State Nurses' Association. Miss Garnsey is a graduate of the Childrens' Hospital of Boston and has had a varied nursing experience in New York, particularly in the western part of the state.

Rhode Island: Providence.—The regular meeting of the RHODE ISLAND STATE ORGANIZATION FOR PUBLIC HEALTH NURSING was held November 15 at the Medical Library. Dr. Lucy Bourn gave a description of Child Welfare in China. Mrs. Austin Levy gave a report of the Board meeting held in New York; Dr. Ellen A. Stone reported on the American Public Health convention held at Palmer, Ohio. Mrs. Henry E. Pearson of Newton, Mass., instigator of the Nursery School Movement in America, gave a review of the movement in this country and in England.

District and Alumnae News

District of Columbia: Washington.—The October meeting of the DISTRICT LEAGUE OF NURSING EDUCATION was held at St. Elizabeth's Hospital, October 27. Dr. J. Fong lectured, and with two assistants demonstrated the treatment of general paresis by inoculation with malaria.

Illinois: Chicago.—The Illinois League of Nursing Education met December 15, at the Chicago Nurses' Club. Dr. Joseph Baer, Assistant Professor of Gynecology and Obstetrics, Rush Medical College, gave an address on "Prenatal Care." Students of the Presbyterian Hospital School of Nursing sang Christmas carols.

Indiana: Fort Wayne.—The annual meeting of the First District Association was held November 12 at the Anthony Hotel with a luncheon. Mr. O. Scheiman gave a very helpful talk on "Safe Investments." Edna L. Foley of Chicago, Superintendent of the Visiting Nurse Association, gave a very interesting talk on "The Public Health Nurse and the Crippled Child." Officers elected are: President, Mrs. G. Van Sweringen; vice presidents, Elizabeth P. Fitman, Margaret Frysinger; secretary, Adele Fruechte; treasurer, Esther Ley; directors for three years, Anna M. Holtman, Nora G. Tudor, all of Fort Wayne. **Richmond.**—The Alumnae Association of Reid Memorial Hospital held its annual meeting on November 16 and decided to hold a rummage sale for the benefit of a library for the student nurses. **South Bend.**—The Second District held its annual meeting at the Epworth Hospital, November 12. Officers elected were: President, Mary J. Callahan, Mishawaka; secretary, Mabel Ackley, South Bend; treasurer, Leona DeGroot, Mishawaka. Lula Cline and Kacid Laurence gave reports of the State meeting.

Kentucky: Covington.—The Northern District of the State Association was recently organised with headquarters at Covington, thirteen counties being included. The officers are: President, Margaret Valentine, Cincinnati, Ohio; vice presidents, Carmelia Powers, Covington, and Mrs. Francis Wyatt Schairbaum, Dayton; secretary, Helene G. Schlosser, Covington; treasurer, Anna Pracht, Newport; directors, Martha Pederson, Susan Salt, Olive Soden, Mabel Gaskins, Agnes Cleary, Mrs. Rose Dean. Chairman of committees are: Credentials, Mabel Gaskins; Program, Josephine Myers; Press and Publication, H. G. Schlosser.

Louisiana: New Orleans.—A very enjoyable reunion of friends and graduates of the New Orleans Sanitarium was held recently, in the form of an old-time party. The school was taken over by the Presbyterian Hospital in 1912. Mrs. Lydia Breaux is President of the Alumnae Association.

Massachusetts: Boston.—The New England Industrial Nurses' Association met in the Town Room Library, November 12, and enjoyed two excellent addresses. Florence H. Luscomb of the Joint Board of Sanitary Control of New England, spoke on "Clothing American Women," meaning the problems of the sweat shop. She urged the members to buy goods with the Proganis label which means that the consumer is protected from disease-laden garments and the worker from sweat shop conditions. Dr. Francis D. Donahue, medical advisor to the Massachusetts Industrial Accident Board, spoke on the Industrial Law and its working.

Michigan: Marquette.—On October 28, Mary C. Wheeler, General Secretary of the State Association, met many members of the Marquette District at a dinner meeting held at St. Luke's Hospital. She gave an account of the meeting of the College of Surgeons and of Dr. Burgess' splendid reports. The annual meeting of the District will be held on January 9 at the Marquette Federated Women's Club House. All members are urged to be present.

Missouri: St. Louis.—Edwin R. Embree of the Rockefeller Foundation spoke on "Nursing in the Modern World" at the opening of the addition to the Nurses' Residence, Washington University School of Nursing, November 20. The addition, which gives a total capacity of 386 residents, includes living quarters, a large lounge, reception rooms, library, offices for the school, classrooms, dietetic laboratory, and solarium. The Jewish Hospital reports a gift of $300,000 toward a Nurses' Residence from Mrs. Moses Shoenberg and her son in memory of Moses Shoenberg who had been under the care of nurses during a five years' illness.

New York: Buffalo.—District 1 held a meeting on November 16 at the Nurses' Home of the Buffalo General Hospital. Reports of the State meeting were given by the delegates. An illustrated lecture on Dental Hygiene and the Nurse was given by Dr. E. F. Mimmack. At a former meeting it was decided to hold but five meetings during the year. The School of Nursing Committee of the Millard Fillmore Hospital now includes a representative from the Nurses' Alumnae Association. **Ithaca.**—The Ithaca Memorial Hospital Alumnae held their November meeting at the Community Building. It was decided to allow the Sick Nurses' Fund to accumulate to a certain amount and then to use it as a Loan Fund. A report of the State meeting was given. The members expressed their pleasure in the election of Mrs. Clifford, Superintendent of the Hospital, as President

of the State Association. New York.—Edith Summer Camp at Norwalk, Conn., bequeathed to the Bellevue Training School in 1899, has been sold. The income from the fund will be used for vacations in places chosen by the nurses, themselves. Mt. Sinai Hospital on November 30 held open house at the new Nurses' Home and School. Rochester.—The annual meeting of the Genesee Hospital Alumnae was held in the Eastman Home on November 7 with seventy members present. Officers elected were: President, Mrs. Doris Van Zandt Chambers; first and third vice presidents, Grace Hanes and Florence Padgham; treasurer, Mary Harriman. Utica.—District 7 sponsored a splendid mental hygiene meeting at the auditorium of the Utica State Hospital, on December 7, Dr. A. H. Ruggles, Superintendent of Butler Hospital, Providence, R. I., addressed the gathering on "Mental Hygiene in Public Health Work." Three hundred and fifty persons attended. Emily Hicks, President of District 7, presided and introduced Dr. R. H. Hutchings, Superintendent of the Utica State Hospital, who welcomed the visitors. She then turned the meeting over to Professor Milledge L. Bonham, Jr., President of the Oneida County Council on Mental Hygiene, Dr. Andrew Sloan, President of the Academy of Medicine, Dr. Hyser Jones of the Oneida Co. Medical Society, Dr. Charles Bernstein, Superintendent of the Rome State School and Mr. I. W. W. MacClain, President of the Council of Social Agencies, all of whom discussed Dr. Ruggles' paper. All of these organizations had been invited and were well represented. After the meeting, the ladies of the Oneida County Council on Mental Hygiene were hostesses at an informal reception in the Social Service Department.

North Carolina: Winston-Salem.—The Winston-Salem Nurses' Association, District 2 held the monthly meeting, November 10, at the Y. W. C. A. After a short business session, Miss Havey from National Red Cross Headquarters at Washington, D. C., gave a most interesting address. She spoke principally of enrollment of nurses; the disasters of the present year; the department of Home Hygiene Service. The district has had a very active year. The program committee has furnished an interesting program for each meeting. Several of the prominent doctors have given highly instructive talks on the various specialties of their profession. The Ways and Means Committee has worked very hard and has added materially to the finances of the Association. A substantial contribution was made to the Mississippi flood sufferers. A yearly sum was pledged for the National Grading Committee. Ice cream was sent weekly to the local tubercular hospital, during the summer months. The Association has also taken steps toward having its own Club House, and a nice sum of money has already been realized for that. At the October meeting the alumnae associations of the North Carolina Baptist Hospital, and of the Lawrence Hospital were taken into the District. Rocky Mount.—District 8 held a regular meeting, October 11, in the First Baptist Church with an attendance of thirty-two. A letter from the Grading Committee was read and discussed. Mr. Fountain, Speaker of the House of Representatives, gave an interesting talk.

Ohio: Cincinnati.—District 8 is raising money for district headquarters by means of a theatre party. The Alumnae Association of the Jewish Hospital School of Nursing met December 12, at Strauss Hall. Mrs. Louis Hillhouse gave a lecture on "The Human Side of Government." The student body of the School of Nursing will arrange the program for the next meeting, which will be held January 9. Cleveland.—The City Hospital Alumnae Association held its September meeting at the Nurses' Home, with a large attendance. Life membership was discussed. The October meeting was held at the Nursing Center with Mrs. Koch and the freshman class as guests. At this meeting each freshman was adopted as a "little sister" by Alumnae members. November was the "Home-coming," an event which is looked forward to from year to year. On the first Wednesday in November of each year, the graduates of the School of Nursing return to their Alma Mater for a family reunion; 200 nurses came to attend this "Home-coming." A meeting of the alumnae followed the social festivities. Youngstown.—On November 16, District 3 held a meeting at the girls' rest room of Strouss-Hirshberg's store, with an attendance of sixty. Following the musical program, Lucy James gave a talk on "Budgetting" and Mr. C. A. Marstellar spoke on "Annuities," after which came a business meeting and social hour. The annual meeting will be held on January 18 at the Stambaugh Nurses' Home, Youngstown Hospital.

Oregon: Portland.—District 1 voted to contribute $50 to the Grading Committee, the amount to be paid in $10 installments, covering a period of five years. A Hostesses' Committee for Central Headquarters has

been established. The Private Duty Section served during November and December.

Pennsylvania: Philadelphia.—At the annual meeting held at the Walbarton House, June 6, a merger was made by an unanimous vote, between the Gynecean Nurses' Alumnae Association and the University of Pennsylvania Nurses' Alumnae Association, and on November 7, all books and records were turned over to the treasurer. All communications relative to the Gynecean Alumnae Association will be taken care of by the University of Pennsylvania Hospital Alumnae Association, Mary Walbert, President, 3950 Pine Street. Dedication ceremonies of the New Philadelphia General Hospital were held on December 7. The Women's Homeopathic Hospital held a capping party on September 1 for the nineteen students who had completed the probation period. The president of the Senior class presented the caps. The Misericordia Alumnae meet on the third Monday of each month. At the November meeting, Margaret Gough gave a report of the state meeting. The Guild of Our Lady of the Visitation, at the October meeting, enjoyed an address on the History of Nursing by Dr. James Walsh of New York. At the November meeting, Dr. Gabriel Tucker spoke on Bronchoscopy. Pittsburgh.—The graduate nurses of the Western Pennsylvania Hospital held a "Home-coming" in the Dormitory of the School, November 17. The Training School was organized in 1892 with ten student nurses, Mrs. Kate Wynn Hoffner being the first to enter the class. Four of the first class were present. The Hospital has graduated 1,100 nurses to date. Anna McMillan of the Bellevue Hospital, New York, was the first Superintendent of Nurses and was succeeded by Caroline Milne of the Presbyterian Hospital, Philadelphia. The luncheon was attended by 362 nurses. This was followed by a reception and reunion of classes. Special features of the afternoon were: A short talk by Jessie J. Turnbull, a former Directress of Nurses, and the presentation of a silk flag to Mr. Eichenlaub, Superintendent of the Hospital. The entertainment of the evening was opened by a banquet, with three hundred nurses attending. C. Ruth Bower, the Directress of Nurses, was the main speaker of the evening. The banquet was followed by a reception and dance. Scranton.—The regular meeting of District 3 was held at the West Side Hospital, with an attendance of fifty-three. The President gave a very interesting report of the State convention. The plan for the Grading of Nursing Schools was also explained. It was voted to contribute twenty cents per capita for this work. Three alumnae associations have already pledged to contribute.

Texas: Galveston.—District 6 held its annual meeting recently and elected officers: President, Mrs. S. N. Hausmann; vice presidents, Rose Lee Arms, Josephine Newbill; secretary-treasurer, Zora McAnelly; directors for one year, Ethel D'A. Clay and Alma Scholss; for two years, Margaretta Perkins and Zulme Tausin. Wichita Falls.—The Eleventh District held its annual meeting at the General Hospital, November 17, at which the following officers were elected: President, Eva M. Wallace; vice presidents, Mildred McCarthy, Rose Adams; corresponding secretary, Dorothy Loops; secretary-treasurer, Mildred Baker; directors, Bertha Michna, Ann Vandiver. Preceding the election, reports from the association were heard in which a membership of 121 was announced. The Past President gave a brief address stressing outside contacts as a means of developing personality. Five nurses were accepted into membership. Following the business meeting, A. Louise Dietrich, State Educational Secretary, gave a very interesting talk on "Grading of Nurses" dealing with a solution of present-day nursing problems.

Virginia: Harrisonburg.—The regular meeting of the Rockingham Memorial Hospital was held November 15, in a part of the classrooms recently completed. The Alumnae gave a desk and chair to be used in this room.

Deaths

Joyce B. Andrews (class of 1901, Danville State Hospital, Danville, Pa.) on October 19, at the Geisinger Memorial Hospital, Danville.

Edna G. Austin, at the University Hospital, Ann Arbor, Mich., July 7.

Elizabeth G. Gilmore (class of 1926, North Adams Hospital, North Adams, Mass.) at the Putnam Memorial Hospital, Bennington, Vt., October 7, following an operation. Miss Gilmore was a member of the nursing staff of the Putnam Hospital and of the alumnae association of her own school.

Mary E. Hausknecht (class of 1903, Orange Memorial Hospital, Orange, N. J.) on November 14, at Colorado Springs, where she had worked as a tuberculosis nurse for many years, after some years of work in Orange. Miss Hausknecht became infected from the

prick of a thorn and died after weeks of great suffering borne with continued cheerfulness.

Virginia B. Jordan (class of 1902, Danville State Hospital, Danville, Pa.) on November 9, at the hospital, after a lingering illness.

Sophie Kuryla (class of 1924, Ithaca Memorial Hospital, Ithaca, N. Y.) on December 1, after an illness of a year with pernicious anemia and endocarditis. Miss Kuryla had done private duty at the hospital and was well liked by all who knew her.

Aagot Larsen (class of 1904, Ullevaal Municipal Hospital, Oslo, Norway) in October. Miss Larsen was in England for one year, studying, and she was a student at Teachers College, New York, 1920–21. Since 1912 she had been instructor in the School of Nursing of the largest hospital in Norway, the Ullevaal Municipal. Miss Larsen was one of the foremost active nurses in Norway, a charter member of the Norwegian Council of Nurses. She was beloved by all who learned to know her. She had a fascinating and lovable personality, with exceptional ability as a nurse and a teacher. The nursing organization of Norway and her own hospital have lost a leader.

Harriet L. Leete (Lakeside Hospital School of Nursing, Cleveland, Ohio) suddenly, on November 19 in Brooklyn, N. Y., following an emergency mastoid operation. Two intense interests animated Miss Leete's professional life, her devotion to the Red Cross Nursing Service and her love of children. When death came, she was planning to attend the annual meeting of the National Committee on Red Cross Nursing Service. Enrolling as a member of the Lakeside Unit, she was released to serve successively in the Red Cross Children's Bureau in Paris, as Chief Nurse of the Tent Hospital known as American Red Cross Military Hospital 5 at Auteuil and still later in various capacities in Serbia, where she contracted the typhus that left her with permanently impaired health. Despite this, she became Director of Field Work for the American Child Hygiene Association and continued to function in that capacity for a time after the two national child health organizations merged to form the American Child Health Association. This position gave conspicuous opportunity for nation-wide contacts with nurses and they came to know that to see Miss Leete was to see a friend. At the time of her resignation it was written of her that "very few health workers possess the broad knowledge of child health work, the dissemination of which was one of the chief contributions that Miss Leete made to the country at large." Characteristically, as Director of a Convalescent Home, at Far Rockaway, she was still caring for children at the time of her death. She was a loyal friend—a friend to children and a friend to hundreds, obscure and great, of her own profession. Burial was at Hartfield, N. Y., with military honors. Tributes were received from many associations with which Miss Leete had been connected.

Leah Northrup (class of 1912, Samaritan Hospital, Philadelphia) suddenly, on June 17, at the Lutheran Hospital, Cleveland, Ohio. Miss Northrup is missed by her classmates.

Hazel Ramsey (student, class of 1930, Morningside Hospital, Tulsa, Okla.) on September 16, at the hospital, after a short illness. Her fellow students attended the funeral.

Henrietta Van Cleft (class of 1895, Presbyterian Hospital, New York) at Stamford, Conn., on November 1, after a long illness. Miss Van Cleft was a member of the Henry Street staff for some years after her graduation; she then went to Lakeville, Conn., and spent the rest of her life as visiting nurse devoting herself without stint to the needs of the community, rendering a service greatly appreciated over a wide countryside.

Eliza W. Ward (class of 1890, Orange Memorial Hospital, Orange, N. J.) on November 11, at Vineyard Haven, after a long illness with much suffering from arthritis, borne with great patience.

THEN the sails of faith she spread,
And faring out for regions unexplored,
Went singing down the River of the Dead.

—ELSA BARKER.

About Books

THE PRESCHOOL SERVICE IN A GENERAL HEALTH PROGRAM. Practical Procedure in the Home, in Medical Conferences, and in Mother and Child Classes. An East Harlem Nursing and Health Demonstration publication. Illustrated. 124 pages. Price, 55 cents.

A PRESCHOOL population of 6,000, in a single small area of a highly congested industrial city affords a rich field for the development of an educational health service.

The booklet on preschool work which has just been published gives in outline form the standards which have been evolved by the Demonstration staff of East Harlem during the last five years.

The booklet covers, in Part I, the material included in the introduction of the new staff worker to the service, the aims and policies of the service, and facilities for child care. Teaching devices are presented and elaborated by discussion. Some of the topics which are discussed are: the essentials of the home visit; the educational aspects of the medical conferences, the details of management, equipment, and routine; the purpose and procedure of such auxiliary services as the posture class, the health habit class, the special nutrition conference, and the mothers' class.

Part II gives in outline form a series of 14 lessons which are taught to groups of mothers of the preschool children. The leaflets which accompany the lessons are used in connection with the home visiting and in the medical conferences, as well as in the classes, and summarize the main teaching points of the preschool service.

This booklet does not give analyses of the results of the work. It is devoted to methods and content of instruction. The illustrations which accompany the text show the equipment and clinic set-up, posters and demonstration material, groups of mothers and children participating in various activities, a district home in which the mother is keenly aware of her responsibilities, and a group of fathers who are glad of the opportunity to learn about child care.

This booklet should be useful to instructors in school nursing, pointing out as it does the common problems that are met by public health nurses in district homes and the methods whereby the problems are attacked. The booklet might also suggest to principals of schools of nursing, a possible solution to their problem of where to obtain adequate pediatric service for their students.

The booklet is one of a series which includes: "The Cost of a Program of Health Activities with Special Emphasis on Public Health Nursing," "A Comparative Study of Generalized and Specialized Nursing and Health Services," "Lesson Outlines for Maternity Classes," and several reprints of articles on nutrition work and tuberculosis nursing.

OBSTETRICS FOR NURSES. By Joseph B. DeLee, M.D. Eighth edition, revised. Illustrated. 635 pages. W. B. Saunders Company, Philadelphia. Price, $3.00.

IN the preface to this, the eighth edition of this popular and important textbook, Dr. DeLee says:

> Very little of the text could be left out, but several of the illustrations, grown obsolete, were omitted, giving room for the insertion of some new subjects. These are: the iodin and mercurochrome preparation of the parturient for labor, Gwathmey's synergistic

obstetric analgesia, the identification of newborn babies in busy maternities, and several minor matters.

More than half of the babies are as yet born in the home, therefore home obstetrics has to be taught, together with that of the hospital. While there are no differences in principle, the details vary, and these have been consistently emphasized throughout the book. Many of the illustrations have been redrawn and several new ones were added.

OUTLINE OF MATERIA MEDICA AND SPECIAL THERAPEUTICS. By Sister M. Domitilla, R.N. Paper bound. 101 pages. W. B. Saunders Company, Philadelphia. Price, $1.50.

THE "Outline of Materia Medica and Special Therapeutics," now in its second edition, has already found a place in the educational scheme of many schools of nursing. It has several rather distinctive features which make it practically useful in the teaching of this difficult subject.

In part one of the Outline there is a well organized course in elementary materia medica, including problems in the metric system, in percentage, in ratio and proportion, in the calculation of dosage and the making of solutions from stock solutions. Accompanying each lesson in the mathematics of the course, is an outline for a laboratory lesson during which the student prepares the doses or makes up the solutions which have been the subject of her recent blackboard calculation.

The second part of the Outline is to be used when the student is ready for advanced materia medica, and here again, the author has departed from the usual textbook methods. Thirty-eight pages are given to a tabulation of the commonly used drugs under the following headings: "Name of Drug," "Source," "Action," "Result of Action," etc., a total of eleven headings being used for each of the forty-eight drugs listed. The student, presumably, is to make the answering of these questions a matter of individual research by using other texts and reference books. For, as stated by Sister Domitilla in her preface, "the Outline is not intended to take the place of a textbook." Although only forty-eight drugs are named, there are eight tabulated pages on which other drugs used in the hospital may be listed.

The third part of the Outline deals with the course of special therapeutics for the third year student.

The general plan of the Outline would at once commend itself to the teacher who desires to secure the maximum amount of student activity and who often finds it difficult to have stimulating lesson outlines prepared in advance. Perhaps many teachers would find the tabulation more useful if no drugs had been listed except the two used as examples of method. It would be easier for the individual teacher to take up the drugs in the order, and under the classification, which seemed most suitable to her.

The inclusion of the subject "Requirements for a Drug as a Satisfactory Therapeutic Agent" seems questionable. Is not such a requirement a matter for medical decision and quite outside the jurisdiction of the nurse?

Probably no two teachers will use the Outline in exactly the same way, but many will be grateful to Sister Domitilla for arranging in so helpful a way the essentials of the three courses in materia medica and therapeutics. The Outline may be used, as arranged, for a minimum standard in the subject; or it can be supplemented, to make it as inclusive and exhaustive as the teacher desires.

MABEL F. HUNTLY, R.N.
Philadelphia, Pa.

Some Other Books Worth Reading

By Isabel Ely Lord

IT may seem strange to urge busy women to read two large and, at first sight, formidable volumes, but "The Rise of American Civilization," by Charles and Mary Beard, is not only so important but so fascinating, that no one should miss it. It is not history in the usual sense, but social history—how our problems of the past and present arose, what those of the future seem to be, how we have met or not met those of days gone by, what we may or might or should do to meet those of today and tomorrow. It is fascinating reading, carrying one on from point to point of our national development so easily that, though we start to read one chapter at a sitting, we find ourselves reading four or five because we want to know what comes next. And it is a book we do not need to read, if time lacks, in a few days or even a few weeks, but can pick up whenever we get hold of it and go on from where we left off. It is "an education in itself" for Americans, and such a pleasant one!

Carl Sandburg's "American Songbag" is a mine of delightful, sad, gay, amusing, anything-you-like songs, as sung by all kinds of people all over our country. The notes of introduction by Mr. Sandburg add much to the enjoyment of the reader, and you almost hear him singing the songs while he thrums his old guitar. Not a book to read straight along, but one to dip into often, with a prize certain for every dip.

When Padraic Colum took "The Road Round Ireland," it proved to be for our delight no less than his. Poet, dramatist, teller of tales for children, Irish to the core, having lived in Hawaii and now abiding in peaceful Connecticut, he brought so much to his journey that these pages fairly spill over with goodies for the reader. Perhaps most of all it is the poet's book, but the dramatist and the tale-teller are there in good measure, too.

"Death Comes to the Archbishop" is Willa Cather's latest—shall we say novel? It seems an odd word to use for so real a book. Some of us will probably always cherish "My Antonia" beyond anything Miss Cather will ever write, but in this story of a French priest in New Mexico, in the middle of the last century, she gives us a book in which her art is at its best—serene, looking at life with wide vision, moving us like a piece of life itself.

A saga of pioneer life in America is O. E. Rølvaag's "Giants of the Earth." The Scandinavians in Dakota when they came to break new ground, with all the hardships of their struggles, all the beauty of their life, too—a story that well justifies the word "giants" in the title. It is a great chunk out of real life, deepening and refreshing life for the one who reads.

Did you know that you could now get the short stories of O. Henry complete in one volume? Over seven hundred of them, on thin paper, of course, but clearly printed and not too heavy a book. Doubleday, $3.

Did you know that Doubleday had issued the complete poems of Rudyard Kipling in a single volume? $5.

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